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HEALTH

The courage to care

General editors
Dr Godfrey Gunatilleke & Dr Aleya El Bindari Hammad

World Health Organization
Geneva

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A critical analysis of WHO's leadership role in international health by the Task Force on Health in Development

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World Health Organization
Geneva
1997

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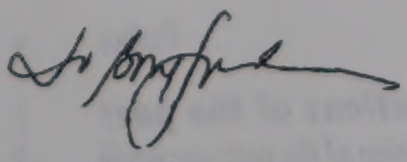

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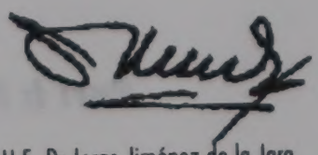

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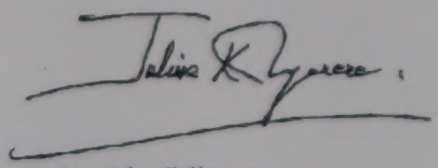

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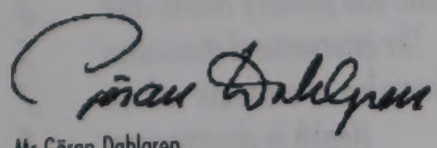

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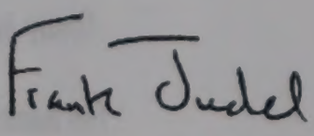

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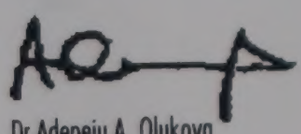

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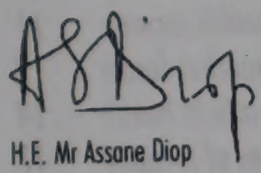

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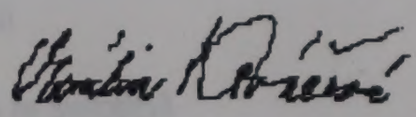

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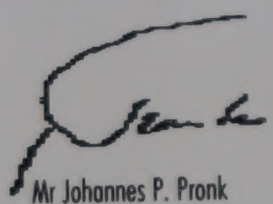

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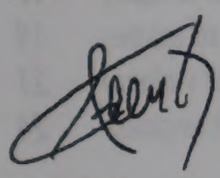

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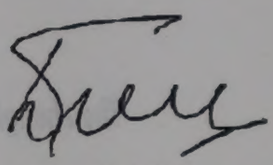

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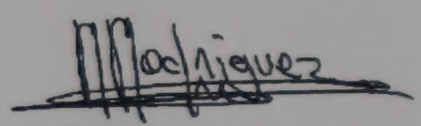

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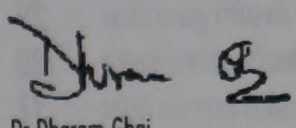

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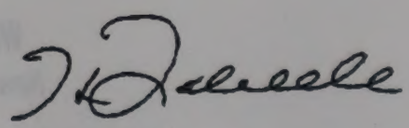

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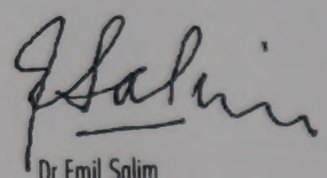

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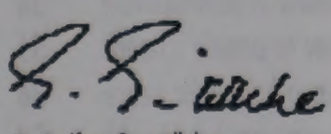
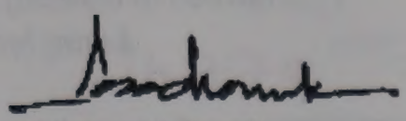


Mr Godfrey Gunatilleke



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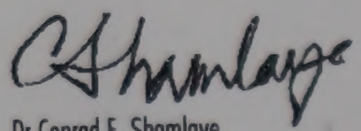

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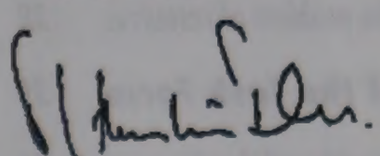
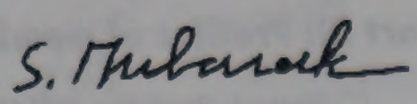


HRH Crown Prince El Hassan Bin Talal



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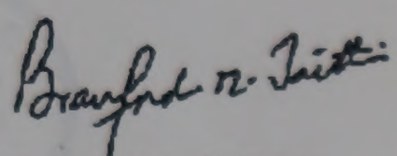
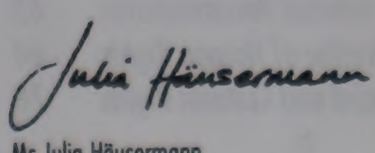


The Honourable Branford M. Taitt



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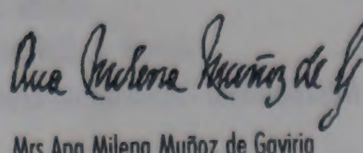

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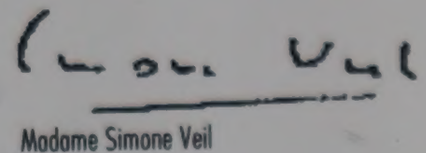

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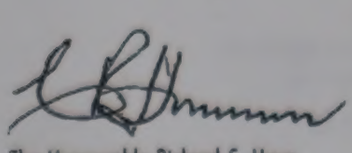

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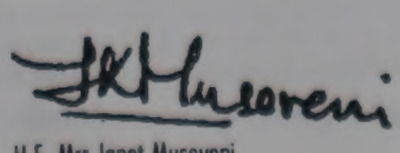

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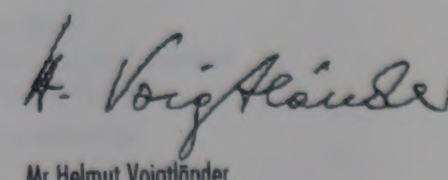


Mr Helmut Voigtländer

Preface

Resolution WHA45.24 recommending the creation of the WHO Task Force on Health in Development was unanimously adopted by the World Health Assembly in May 1992. An eminent group of personalities from a cross-section of disciplines was established by the Director-General to undertake the following tasks:

1. to study existing global development policies, strategies and programmes to determine which factors enhance and/or hinder the promotion and improvement of health status;
2. to analyse health status indicators and their relation to economic development with emphasis on the situation of most vulnerable groups;
3. to examine alternative funding mechanisms which would help countries evaluate the interaction of health status and economic development strategies;
4. to explore ways and means of improving access to basic education, credit facilities for small industries, and other means of assisting countries to improve the health status and to protect the health rights of the vulnerable groups;
5. to recommend appropriate arrangements for the protection of basic health as a human right and, in consultation with all partners concerned, to initiate a process of education and consensus-building to ensure that health status is protected in the development process.

Between May 1992 and the first meeting of the Task Force in June 1994, the world climate and perceptions of health in development had changed markedly. A shift from centrally planned to market-driven economies had taken place, as well as the globalization of the economy and privatization, the conclusion of the Uruguay Round of the GATT negotiations, and the spread of war, regional conflict and ethnic strife. Such factors had wide-ranging consequences for human health and well-being in developed and developing countries alike.

Of particular concern has been the recognition of a global "health crisis", characterized by a worsening of health status, especially of the most disadvantaged groups. An increase in life expectancy has been achieved, but the elderly often suffer conditions of great deprivation

and misery. The health crisis has also led to the creation of new vulnerable groups and increasing inequities, which has contributed to social conflict and violence.

The Task Force was aided in its analysis by the pioneering work carried out by Member States, particularly those in Africa, in partnership with WHO. In this work, the health status and quality of life of the most vulnerable and disadvantaged groups was improved substantially through activities which work simultaneously towards improvement in economic status, literacy and community-based health services. These successful efforts to put health at the centre of the development process in deprived communities gave the Task Force one of its principal reasons for existence as articulated in resolution WHA45.24. The Task Force has been an important voice calling the attention of the world to these successes and has demonstrated that the protection and promotion of health are at the very heart of the development process. The Task Force has sought to assure that the powerful policy implications of these experiences in health and development are recognized and built upon.

The evolving world health situation guided the discussions at the first meeting of the Task Force, where four strategic areas in which major development issues interact closely with critical health issues were highlighted for particular focus in the Task Force's Plan of Action. These are as follows:

- equity in health and market forces;
- the quality of life and health security of specific population groups;
- accountability for health; and
- health as a bridge for peace.

The need for global health leadership to provide guidance in responding to the health crisis, and for foresight in using health to shape a better world, was clearer than ever. WHO was deemed uniquely able to provide such essential health leadership, as it has the credibility and experience to steer the world into a new era for health in the twenty-first century. WHO must, however, seize every opportunity to advocate the policies and programmes of the Organization, and to guard against pieces of the international health agenda being implemented out of context by increasing numbers of players, often to the detriment of the whole. Health programmes cannot be sacrificed as a means of responding to the national, international and supranational financial crises of the late 1990s.

It is within this context that the Task Force laid out a set of advocacy targets exploiting the opportunities offered by the many international conferences that had been planned at that time.

One such opportunity was provided by the World Summit for Social Development (WSSD), held in Copenhagen in 1995. This Summit was seen as an important vehicle for moving forward in a critical way towards the recognition that economic growth is not enough to meet the development needs of a country, and that the fruits of growth must benefit everyone. The United Nations Under-Secretary-General and Chairman of the Steering Committee for the WSSD was invited to a meeting of the Task Force so that the message of the central role of health in social development could be incorporated into the preparatory process for the Summit and its outcomes.

This step was instrumental in opening avenues for Task Force members and WHO to ensure that health concerns formed an integral part of the preparations for the Social Summit. Task Force members pursued their unyielding advocacy efforts, working with country delegations to negotiate the inclusion of the tenets of the "Declaration on the Centrality of Health in Social Development", adopted in Paris in February 1995. These and many other initiatives resulted in the incorporation of references to health concerns, health indicators and strong political commitments on health throughout the Copenhagen Declaration and Programme of Action. The ardent advocacy work of the Task Force was therefore crowned with success as the final documents of the Summit considered health as a powerful benchmark for measuring progress towards reduction in poverty, promotion of social cohesion and elimination of discrimination.

The same approach was previously used by the Task Force when preparing for the International Conference on Population and Development (ICPD) held in Cairo in 1994. At this Conference, population issues were no longer considered solely in the light of demographic problems. Health dimensions of population issues were paramount. For the very first time, discrimination against women throughout their lives was thoroughly discussed, and the precarious health conditions of women were used to illustrate their disadvantaged and vulnerable status. In this context, the Task Force felt gratified that WHO's scientific evidence was used to provide credibility and to strengthen the formulation of political arguments and strategies.

The Task Force on Health in Development and the Global Commission on Women's Health also made outstanding contributions to two other international conferences. The conclusions of the Fourth World Conference on Women (Beijing, 1995), building on those of the ICPD, firmly reinforced the need for a holistic approach to development, which regards health and other social issues as integral aspects which are central to economic decision-making processes. At the United Nations Conference on Human Settlement (HABITAT II , Istanbul, 1996) the health dimensions of poverty, political empowerment, violence, education and legislation were articulated.

These are but a few of the important achievements of the Task Force during its mandate. Based on this work, members of the Task Force wished to present a coherent and comprehensive view of future health leadership to the Director-General and the Executive Board of WHO (see documents EB99/40 and WHO/HPD/96.10). A synopsis of the future actions to be undertaken by WHO to realize this vision is as follows:

- advocate a global culture of health based on the concept of "health security", whereby health becomes a powerful contributor to social cohesion, peace and a better quality of life;
- convene experts to determine global standards and norms for technical and ethical issues, and develop criteria to guide policy- and decision-making, in matters related to health;
- act as a catalyst in health policy-making, and as a "strategic referee" for the establishment and implementation of a global health agenda with a worldwide network of partners from both public and private spheres;
- monitor health status, project and analyse health scenarios, and develop proactive courses of action to address known or potential threats to health; and
- reduce inequities in health.

The work of the Task Force was never meant to duplicate that of WHO or its Executive Board. It was established as, and always has been, an independent and innovative "think tank". Its function is to submit to the Director-General, to WHO and to its governing bodies concrete and original proposals for securing health in development at the dawn of the twenty-first century, as well as for WHO's role in providing guidance.

When we started our work, WHO was being heavily criticized and the Task Force subjected to increasing presure not to advocate for WHO's work. After studying WHO's policies and objectives and talking with its senior staff, Task Force members became convinced that an important objective was to champion WHO's role in global health leadership and to advocate the outstanding work this Organization carries out; work which has sometimes been buried in interminable reports, accessible to few and comprehensible to even fewer!

In reflecting on the past, current and future scenarios for global health leadership, the Task Force observed that, whilst WHO's mandate provided it with a unique opportunity to exercise this leadership and enjoy an outstanding association with the scientific community, it still relied to a significant degree on its past achievements for current credibility.

WHO's leadership and broad health advocacy roles needed strengthening to ensure that opportunities were not missed and that health issues were given their due consideration in both the global and national debates on resource investment and priority-setting.

The leadership role concerns not only the Secretariat but also the Member States who must assume their share of responsibility and pursue the policies which they themselves have formulated.

In the document Highlights of the Fifth Meeting of the Task Force on Health in Development (November 1996; WHO/HPD/96.10), we described the far-reaching changes occurring in the world which inevitably require adjustments to WHO's role and mission for the twenty-first century.

Among the questions raised by members of the Task Force were these:

- What kind of health leadership is required for the 21st century?
- Is WHO as it currently stands equipped and ready to fulfil a leadership role for global health?
- What critical capabilities should WHO have in the next century?

It has often been asserted that WHO should focus only on those areas where it enjoys a distinct "comparative advantage". We refuse to accept this concept of "comparative advantage". There is no comparative advantage when we talk of global health leadership. We are not in the competitive business market and health is not for sale!

In fact, the Task Force was concerned at the level of "market language" that is permeating WHO's work and much of what one reac and hears. We talk of markets, we talk of products, we talk of value for money, but what is at stake is our own health and well-being an these are not market commodities.

As far as the Task Force is concerned, WHO is the leader in global health. But it will take the courage and determination of all of us to keep it that way. We all own WHO, we all want to halt the insidiou undermining of its image. The Task Force, in taking its share of this responsibility, has therefore put forward suggestions to steer WHO forward; these suggestions capitalize on a number of notable oppor tunities.

1. Health is now a powerful political platform. There is a wave of interest in health, in healthy lifestyles, etc. However, interest is no enough. WHO has long proven that inequities — and in particula inequity in health — breed social unrest and lead to many forms of overt and covert violence.

   Here is an entry point for WHO's leadership role: health must be valued in and for itself. The Task Force has advocated various way in which to support this human rights claim. We have witnessed that monitoring the health status of the most disadvantaged and vulnerable population groups in countries is the best indicator of development per se. We have also witnessed that in the increasingly conflict-torn societies of today's world, health is a neutral and universal bridge towards peace.

2. Much progress has been made in the study of health, and in the scientific sphere in particular. More than ever before, we have the means to keep healthy, to fight illness, and to cure disease. WHO should exploit this progress, particularly in ensuring equity in availability of, and access to, health care.

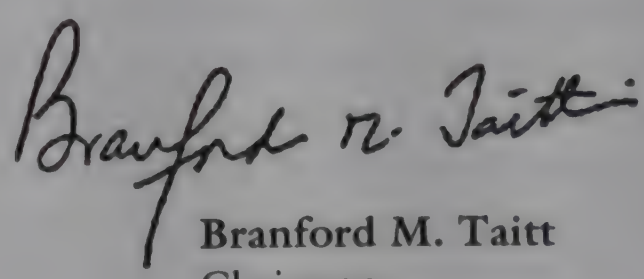
3. Many countries have made gigantic steps in improving their healt status over the last decades, whereas others, despite having higher GNPs, have not. WHO could usefully study these phenomena with a view to adapting its health promotion strategies to suit its respective Regions.

The Task Force's achievements and concrete recommendations to date have been the result of long and earnest reflection, and much of this thinking and many of its views have been incorporated in WHO's draft Health-for-All policy for the 21st century.

Our report is organized along the following lines: in Part I, we analyse issues which we consider of paramount importance in understanding the factors that have contributed to the present health problems and how they could have been avoided or lessened if the world community and WHO had taken appropriate action.

In Part II, we have outlined a vision for the future of health in development and describe the measures the world community, and WHO in particular, should undertake to ensure a better and healthier world for future generations, embracing the challenges of the twenty-first century. Part III provides a brief profile of each member of the Task Force on Health in Development some of the key texts referred to in this document are reproduced in the Annexes.

This report is not comprehensive in that it does not seek to cover ***all*** the health issues in the world today. Nor does it seek to redefine the World Health Organization. We have sought to engage in a reflection on some of the major aspects of our changing world that will have a profound effect on health today, tomorrow and in the 21st century. It is a reflection on the strategic steps which must be taken to protect and promote our health as our wealth. It is a projection of what WHO can, and must, do if it is to ensure its legitimate role as the leader in international public health.



Branford M. Taitt
Chairman
Task Force on Health in Development

Part I
Reflections of the past

We live in a world of stark contrasts. While a few benefit from immense riches, the majority of the population lives in unspeakable poverty. There are widening wealth differentials both between and within countries. It is immoral that some individuals can envisage booking return trips to space, while others are unable to reach a health care institution, let alone feed themselves and their families.

Equally obscene are the needless deaths every year of over half a million women from preventable causes during pregnancy and childbirth. From cradle to grave women suffer disadvantaged health status. This is but part of a bigger picture of health inequities, suffered by all individuals who are subjected to discrimination, and denied their equal rights.

Spectacular advances in medical science are daily news – the fortunate few can avail themselves of extremely sophisticated health care, while cholera rages in our overcrowded, impoverished shanty towns. How can we tolerate a food surplus in some regions, while in others our children perish from starvation, their lives blighted by undernutrition?

Whilst health improvements have resulted in an increasing average life span, the misery in which our elderly often live is very real. A longer life does not guarantee an improved quality of life.

These realities highlight the current emergencies which are plunging the health sector into an unfathomable crisis worldwide. Continuing neglect of the critical links between health outcomes and the processes of economic growth, and insufficient investment in preventive health care by either developed or developing countries are in part responsible for this crisis. The creation of the Task Force on Health in Development in May 1992 was a response to this situation.

To analyse the origins of the health crisis and to find solutions to it, the Task Force needed to step back and review the approaches to development and health that have evolved over the second half of the 20th century. The following paragraphs are a synthesis of the reflections made, the issues identified and the international response to these issues.

The vision of the post-war world

Nations emerging from the Second World War were forming a vision for the future of humanity to ameliorate the trauma of the immense human suffering and loss of economic well-being caused by the war. This new world would need the strength and ability to manage wisely the rapidly increasing potential for well-being as well as for destruction resulting from advances in science and technology.

One of the first post-war tasks was therefore to create a global value system and to establish institutions through which nations could act collectively to ensure peace and security, and to promote economic and social development. The creation of WHO in 1948 as the global organization responsible for promoting human health has to be perceived as part of the wide-ranging effort to realize this vision. The international initiative to establish the Organization was permeated with the moral and ethical aspirations of a world profoundly chastened by the human suffering it had inflicted on itself. Moreover, WHO's unique concern with human health and well-being saw it deeply rooted in the ethical basis of the Hippocratic Oath.

These global initiatives were accompanied by historic changes in various regions of the world which had a far-reaching impact on the evolution of WHO's strategy. For the first time in history, global policies based on international assistance and cooperation became a major instrument of the economic recovery and development of nations. This first found expression in the international effort for the reconstruction of Europe. These development policies were specially attentive to the poverty and destitution left by the war, and States assumed greater public responsibility for the welfare and security of their peoples. The social ideologies that underpinned these efforts were visionary and far-reaching. They promoted the ideal of a caring society struggling to survive today.

In other parts of the world, empires were breaking up and the new independent nations that were emerging were assuming responsibility for their own well-being. Their presence on the world scene and the articulation and advocacy of their needs gave new dimensions to the meaning of development which went far beyond the concepts and goals which guided the reconstruction of Western Europe and the Marshall Plan which supported it

The priorities of WHO

WHO was founded at this decisive turning point in human history, and all the above-mentioned events converged to shape its vision and define its priorities. Any attempt at redressing the health crisis of today should first retrace the major milestones in the Organization's 50-year journey. WHO's initial challenges went hand-in-hand with discoveries in curative and preventive medicine which were providing unprecedented opportunities for protecting and improving the health of populations. At the same time, the international community was alarmed at the unconscionable disparity between the health status of populations being emancipated from colonial rule, and that of the inhabitants of the more developed parts of the world. Together with major advances, pressing hardships were encountered. WHO responded with a broad-based strategy which placed public health at its centre and sought to control the major infectious and communicable diseases which were afflicting large segments of the population in certain countries. WHO helped countries to lay the foundations of a health care system which was to achieve noteworthy, sometimes remarkable, successes in the control of some of the major causes of death and disease. The early successes in the control of malaria and leprosy, and the progressive reduction and eventual eradication of smallpox, are prime examples. The domain of "public" health became more clearly defined; public health institutions were strengthened and given the mandate and authority to be the guardians of the health and well-being of populations in areas which clearly required broad State-controlled measures, both within and across borders.

Equity in health and primary health care

WHO began to face new challenges during the 1970s. The vision of human well-being that inspired the post-war initiatives was beginning to fade and new ideologies which were less mindful of social care and public responsibility were striving for power. The momentum of economic growth enjoyed by developed countries in the postwar period was slowing down, and structural problems were manifesting themselves in the new phenomena of "stagflation" and unemployment. The increasing disillusionment with the existing welfare state was making inroads into development policy. Develop-

ing countries now struggled against the steady deterioration in the terms of trade of their primary products while they sought in vain for world markets to sustain and promote their growing industrialization. At the same time, a new international dialogue on development was beginning, which advocated a more equitable new international economic order. However, the world economy itself was plummeting into a severe crisis which brought about major changes in the international monetary order. This crisis, in conjunction with the steep rise in oil prices, ushered in an era of global economic instability and rising inflation which caused serious hardships to developing countries and retarded their development efforts.

It was against this background of changing global conditions that WHO called attention to the crisis that was emerging in its own domain. Changing population structures, public dissatisfaction, inadequate service coverage, growing inequities in health status, and rising costs of health care were some of the underlying causes of the crisis. Over the years the emphasis had shifted from basic health services to curative care. Urban-based hospitals and curative institutions increasingly absorbed the lion's share of resources, thus leaving little for public health services intended for those who needed it the most. It was in this context that the issue of equity arose, recognizing that every human being is entitled to the best effective care. This entails that everyone should receive the best quality treatment available but without the "fringe benefits" which usually accompany the treatment received in the private sector, such as private wards, sugar-coated medicine and others. Equity should not equate with mediocrity or minimum standards.

In 1973, the need for a major shift in priorities was recognized. WHO confronted this challenge with two major, interlinked initiatives. It redefined the main priorities and tasks of health care in a strategy which was adopted as the Primary Health Care approach in 1978.

The basic concept of Primary Health Care was wide-ranging and visionary in scope. The approach focused on basic and cost-effective measures using simple techniques and organizational strategies, and it addressed fundamental human needs in health. The health care was within easy reach of households and communities and this motivated their participation in the management and improvement of their own health. The Primary Health Care approach recognized that a state of well-being was affected by all aspects of people's lives,

and identified the contributions that other sectors such as agriculture, education, public works, housing and communications needed to provide to achieve good health in their communities.

Along with this redefinition of priorities, Member States declared their commitment to achieving Health-for-All by the year 2000. Although many practical difficulties have stood in the way of its full realization, the importance of the Alma-Ata Declaration lay in the universal acceptance of the goal of equity in health and in the accompanying expression of political will to support it.

The commitment to Health-for-All and the shift of emphasis to primary health care have no doubt had a profound impact on health policy at all levels – national, regional and global. Equity is affirmed as an overriding objective which must shape and direct any health care system. This implies that access to the health care necessary to achieve good health is a fundamental human right of every individual. The state of good health and the means of achieving and protecting it then acquire certain characteristics which distinguish them from the goods and services that are traded in the market, and the protection of health and the provision of essential health care become a public responsibility. It is significant that these positions on health were being taken by the international community while it lay on the threshold of the sweeping global changes in economic policy that occurred in the late 1970s and 1980s – changes that were aimed at promoting the market economy and encouraging privatization, even in the health sector.

Other initiatives taken by WHO are also relevant in this context, and deserve attention, such as the global leadership it provided in defining the limits to which the market should be allowed to control sale of essential drugs, and the marketing of tobacco products and infant foods.

The intersectoral dimension

The emphasis on equity and primary health care produced another change of a pervasive nature in the traditional approach to health. The strategy of primary health care treated the protection of health and the attainment of good health as the outcome of a combination of many conditions. Health care, education, nutrition, water, sanitation and housing needed to be integrally linked. As a result, success-

ful health outcomes were progressively perceived to be the result of an intersectoral approach, and this became recognized as central to the agenda for achieving good health. Moreover, issues relating to the intersectoral linkages affecting health were recognized to go beyond the boundaries of primary health care alone. The Technical Discussions during the World Health Assembly in 1986, which were devoted to intersectoral issues in health, focused on the crucial links between health and the development processes and activities in several areas such as agriculture, industry and education. To be effective, health policy had to identify and act upon the sources of ill-health. Epidemiology was expanded to encompass to an increasing extent areas such as chemical pollution, occupational hazards, risk of injury, and changes in behaviour and life-styles. The task of identifying these health-development links, monitoring them and designing the right policy responses and other health interventions was becoming increasingly complex, yet critically important.

While the health sector has an important role to play in the identification of health-development links, it has the same role to play in contributing to the successful achievement of other sectoral interventions in support of health. For example, the full benefit of investments in education can be realized only when the health sector itself invests in ensuring the health of school populations. Educational resources are wasted when children who attend school cannot learn and benefit from educational opportunities and facilities because of nutritional, micronutrient or other deficiencies which result in lack of concentration, poor eyesight and hearing, and other preventable health conditions.

Similarly, major development projects in agriculture or industry will maximize return on investment when concurrent attention is paid to the health status of populations. The elimination of onchocerciasis served not only the cause of improving health, but also enabled previously unusable land resources to be opened up for economic development. These are powerful illustrations of the critical interdependence between sectors such as health and economics, which can be equal partners in contributing to human well-being as the objective of all development processes.

The health dimension of economic reform

A new set of economic circumstances arising out of the crisis in the 1970s and persisting into the 1980s and 1990s changed some of the basic conditions in which countries organized their health care systems. The global economy was moving in new directions. The North-South dialogue for negotiating a more equitable international economic order had virtually collapsed. Increasing reliance was being placed on the liberalization of international trade through GATT and now WTO. With growing restrictions in international capital markets and the contracting net flow of aid, many developing countries were overburdened with debts which they were unable to pay. The import substitution strategies and State-regulated economies of developing countries were failing under the growing dominance of the market economy model and exported industrialization. The collapse of centrally planned economies further strengthened ideologies favouring the market economy.

These changes resulted in economic reforms and structural adjustments that often led to severe constraints on public health expenditure. More important, the new policies which promoted the market economy and privatization tended to erode some of the fundamental values of equity and public responsibility that had shaped the health strategies promoted by WHO. It was in this context that WHO organized the Accra Conference on "Health – A Conditionality for Economic Development" in December 1991, which upheld the view that the protection and improvement of the quality of life are much more complex and challenging than envisaged in past strategies. It was noted at this Conference that the conditions which lead to vulnerability cannot be considered in isolation, but are integrally linked and constantly reinforce each other, perpetuating conditions such as low productivity and social marginalization. It was felt that the development strategies which sought to transform vulnerable groups and lift them to a higher state of human development failed to act simultaneously on all the main conditions which were responsible for their vulnerability and disadvantaged status. Special attention was paid to women as a particularly vulnerable and disadvantaged group, both because numerically they represent the largest group of providers of all types of health care everywhere in the world, and because, while they make an essential contribution to economic development, they are often the first to suffer in times of economic adjustment and the last to reap the benefits of development.

The need to build on successful initiatives in working with disadvantaged groups where there is a simultaneous improvement in health status ***and*** a relative reduction in poverty levels is imperative if one is to move from ***talking*** about the poor, to ***doing*** something concrete about them with positive results. Among the most innovative experiences which *de facto* contributed to our establishment as a Task Force has been the specific work carried out with the most disadvantaged groups in communities in Africa. These groups were women whose profile illustrated their impoverished status: they suffered poverty in terms of income, in education and information, in health status and in access to goods and services.

These experiences have also demonstrated the difficulty in fostering human development when it is based on preconceived packages of services that emanate from outside the community and they have confirmed that working successfully to alleviate the problems of the poorest of the poor entails a commitment by the communities themselves and the involvement of the recognized community leaders, as well as the official leaders. It also requires the creation of a multifaceted approach that builds on the most relevant factors; those that will make a difference according to the people themselves.

In our experiences, working to increase income alone has its shortcomings, since there is no guarantee that increased income will be used to improve health and quality of life. However, investing in education alone may not be seen by the poorest individuals as providing the economic benefits which they seek first and foremost the improvement of their immediate future. In the same way, investing in improvement in health status may not be appreciated as a means of improving productivity and quality of life. It is the combination of these three elements, education, income and improvement in health status, which will make the difference. The way in which these three elements should be combined differs from community to community. In all cases, all three elements have proved essential in providing the impetus for the most disadvantaged groups to escape from their state of vulnerability.

We also realized that, simple as these interventions may now seem, they have called into question the role played by existing financial institutions in eradicating poverty. This should be seen not only from an economic point of view, but also from a multidimensional angle which, to the extent possible, ensures that access to wealth contributes to an improvement in quality of life that goes beyond

material values. We were aware that these were the forerunners of what is now being widely called "Banking for Health", whereby the provision of loans and financial services to the poorest of the poor has been expanded to include a health component. This qualitative difference is important since health-promotive behaviour does not occur by chance; it has to be planned and built into strategies that combine simultaneous improvement in economic circumstances ***and*** in health status and quality of life.

It is within this context that the Accra Declaration confirmed that the path that had been followed by developed countries up until then had led to conditions of vulnerability and hazards to health and quality of life which were growing in diversity and reaching the limits of sustainability in terms of financial and human costs. These problems had to be remedied within the developed countries themselves, and avoided in the developing world. The search for an appropriate balance in development is one which had to be undertaken by rich countries as well as poor. In this search, the global concern for human health had to take a central place.

Health in development

The Task Force on Health in Development is therefore the product of a long and intensive process undertaken by WHO, which led to the reaffirmation of the value of health and of its fundamental importance for ensuring the quality of life. It must, therefore, be guaranteed a place in the centre of our development goals and our development agenda. In the pursuit of development, societies will be confronted constantly with the trade-offs between health and economic development, between the increased generation of income and the protection and improvement of the health of the population. The global value system has been strongly biased in favour of economic gain at the cost of other invaluable attributes such as health. This neglect, both at the global and the national levels, is often due to a lack of effective advocacy and an inadequate awareness of the intrinsic links between health and development. The responsibility of the Task Force in its critical role of advocacy for health was clearly two-fold. First, it must help to resolve some of the major policy dilemmas which affect the health constituency in development; and second, it needed to redefine the role of global leadership which WHO must provide in the changing health scenario of the 21st century.

The vision which had inspired the Organization at its inception and had defined its role within a global value system advocating caring societies in a caring world had faded. The duty of WHO is to recapture this vision for itself, and to help recapture it for humanity.

The value of health

Health has a value in and for itself. Health is unique. It is both the precondition for a state of well being and a prerequisite for the satisfaction of other needs. This was recognized by the founding fathers of the World Health Organization when they ascribed an intrinsic value to health in the Constitution of the Organization in the following terms:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The commitment to this right depends on the value assigned to health by individuals, States and the international community. It should also be a determining factor in the way States allocate resources to development priorities. However, the compelling force of the commitment did not find concrete expression in national and global policy in the manner envisaged at the time WHO was founded. The right to health was not adequately translated into special claims on available resources nor did health status become the test of social and economic development. Although article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", the implementation of this right remained essentially an ideal, invoked occasionally and finding expression in initiatives such as the commitment to Health-for-All, or in influencing a re-orientation in health priorities as in the emphasis on primary health care.

When we look at the value of health expressed as a right, we must ask ourselves what this means. We know that human beings cannot all be in "a state of complete physical, mental and social well-being"at all times. Biological, genetic, environmental and socioeconomic factors make this impossible.

Another way of interpreting the right to health might be the actual feeling of "well-being", despite a physical or mental handicap. The problem with such an interpretation is that it is subjective. One person's "well-being" may not be the same as another's. How then can we move to a common ground where well-being can be measured, standards set and changes monitored, since the need for health is universal?

Human rights and health security

The Task Force recognized the need to give the right to health more substance and operational content by defining it specifically in terms of the rights to the conditions that enable individuals to attain and enjoy their full potential for a healthy life. Health determinants were also needed to provide the dividing line between a positive experience of good health, or a negative experience with ill-health, disease and infirmity. These same health determinants – for example, the extent to which we enjoy adequate food, shelter, clean water, clothing, income, information, basic services, etc. – are in fact tangible elements which fall under the overarching umbrella of the right to health, and are already enshrined in international conventions. When we interpret health as a human right in this way, we find ourselves in the realm of the known, the measurable, the controllable, since we can act upon health determinants.

From this stance, the Task Force conceived the concept of health security. Health security rests on the principle of equity which allows human beings to live with the "security"of knowing that they have access to health care which is affordable, relevant and of good quality. Health security is needed throughout the entire life span of human beings and encompasses all aspects of the right of every individual to the highest attainable standard of physical and mental health, including the right to food in sufficient quantity and of good quality, the right to decent housing, the right to live and work in an environment where known risks are minimized, and the right of access to education and information on health.

Health and market forces

The dominant issue in health policy today is the respective roles of the market and the state. There is a conflict between the forces pushing for free-market economies in the name of efficiency and the need to ensure equity and social justice in the provision of health care services. Contrary to common belief, it has been shown that investment in health by the State can often be the driving force for modernization, and it is being increasingly recognized that investment in health makes an effective contribution to poverty eradication.

Many economists recognize the shortcomings of the market when applied to health services. Policy-makers must be made aware of the inherent limitations and imperfections of a health care system controlled by market forces. Imperfections are inherent in any market, but the value of health is such that the potentially grave human consequences that could occur in an inappropriately managed health market cannot be allowed.

- The goods and services needed to protect health and cure disease are essential to individuals in a way in which most other goods are not, since positive health is an indispensable pre-condition for the enjoyment of other goods and services. Without the conditions that enable a person to function in normal health, the enjoyment of other aspects of life is impaired or becomes impossible. The degree of impairment depends on the severity of the condition of ill-health. Consequently, positive health and the goods and services needed to achieve it are not tradeable in the same way as other commodities. This attribute of non-substitutability of health and related factors makes health a unique commodity. The State and the market therefore have a singular relationship with health and must adapt themselves to this accordingly.
- While other markets may fluctuate between being "demand-led" and being "supply-led", health care systems are, by definition, a "sellers' market". The consumers of health care have little choice with regard to the time and the resources required to treat their illness; this will be determined by the specific ailment, its severity, the treatment options, and the specialized skills available to them in a particular time and place. Nor can the consumers effectively defer satisfaction of their needs without some cost to their health, the most extreme cost being death. Health care is unique in this respect.

- There is asymmetry in the relationship between health care provider and patient. There may be asymmetry in the relationship between buyers and sellers in any market, but health professionals are not sellers, they are specialized providers of care, bound by a code of ethics and conduct. Nor are health care seekers buyers of health care. They do not seek to buy a commodity or service, but to find help in relieving or preventing suffering.

However, there are qualitative differences in the forms of asymmetry which exist in the provision of health care. The relationship between the recipient and the provider of the service is unequal in that the knowledge and information relating to the service are highly specialized, controlled by the provider, and not easily transmittable to the receiver. Even the language used by health care professionals increases the social distance between provider and recipient. The seeker of health care is dependent on the expertise of the health professional for both the diagnosis and treatment, as well as for the evaluation of the outcome. The feelings of well-being that may be experienced by an individual during the course of, or after, treatment are often insufficient evidence of a successful outcome. The results of treatment must often be confirmed with tests and expert examination. This inequality places the recipient in a position of great dependence on the health care provider. Health care is the service in which such asymmetry exists in its acutest form.

- Left to itself, the market has no mechanism which ensures equity, either in access to health care or in acting upon the determinants of health that ensure equity in health outcomes.
- Market economic principles can be applied to some aspects of health delivery in order to determine, for example, the relative cost-effectiveness of the use of different technologies. However, in other areas, the market as a distributive mechanism can have serious adverse consequences, not only for human health, but also for the respect of fundamental human rights and dignity. Complex ethical issues arise with the voluntary donation of blood and human organs, for instance. Given the fact that such donations can save lives or restore people to good health from conditions of critical disability, should individuals be allowed to negotiate for such donations, and should compensation be offered to the donors? There is certainly evidence of trade in blood and human organs, particularly where poor socioeconomic conditions may induce vulnerable individuals to enter into the trade at grave risk to their health. Technological advances have to be anchored firmly

to a foundation of human values and to individual rights to life and health. If not, they will imperil the basic social institutions which order societies. Abuses are likely to occur in any system, whether public or private. The anchoring will not be done by the market, nor will it be done by States acting alone. It must be achieved through societal choices in which the state, the market and associations of civil society act in close partnership by empowering an authoritative body to ensure that norms and standards are adhered to at all times.

Reflections on the public/private mix in health

Although a market-oriented approach to health has imperfections which cannot take account of the unique value of health and the nature of the health rights of individuals, State systems also have inherent problems which have played a part in the deepening health crisis.

There will always be a part of the public domain in health which must remain a public responsibility: for example, the protection of people from communicable disease, the control and elimination of disease vectors and the control and regulation of known health risks. It is not possible to leave these activities to private enterprise since the benefits of an activity such as epidemiological surveillance or vector control accrue to people in an indivisible form; they create, by their very nature, an environment where positive benefits are collectively enjoyed and are not amenable to delivery through market mechanisms to individual beneficiaries.

There is no health care system in existence which provides a perfect mix of the public and private sectors in health. At the extremes, they illustrate the grave imperfections and deficiencies of each.

- The State monopoly of health in the centrally planned economies produced dramatic improvements in health in the early stages, but it does not appear to have adjusted to the conditions that followed the initial decline in mortality, or to the increase in the burden of noncommunicable diseases.
- The excesses of the market and the privatized health care systems regulated by market forces are amply demonstrated in many developing countries which have failed to develop effective regulatory systems for quality assurance, ethical practice and fair prices in

private health care, dispensing of drugs and diagnostic treatment. Nevertheless the demand for private health care has grown in these countries, and surveys provide evidence that even members of low-income households seek private services, particularly in ambulatory care. The preference shown for private services over State services even when they are at times available free of cost, indicates that some of the problems in the State sector are deep-seated. The State sector is perceived, rightly or wrongly, as being inefficiently administered causing a great deal of inconvenience to the users; the relationship between care provider and the care recipient is believed to be highly impersonal and unequal and little or no effort is made to inform the care recipient and enhance his or her responsibility for self-care. It could be argued that these failings are not exclusive to the state sector, but are part of the prevailing health culture and professional ethos of a society, and that they are equally likely to be found in the private health sector.

- It must be noted that individuals' perceptions of what constitutes a quality service are changing. Among health-literate populations with income levels that afford them wide choices in health care, there has been a significant move away from seeking out costly, highly sophisticated care and prestigious technology applications. Disillusionment is spreading with the dehumanization which characterizes such care, which has become the hallmark of many private health care institutions. The present trend is towards more humane care, which takes account of the importance of maintaining dignity and the need for human contact in dealing with natural processes such as childbirth, the recovery from illness and the accompaniment of the dying.
- In the past, public health institutions and services enjoyed a pre-eminent place in society. The working conditions of health workers and the accompanying professional were of high quality. The gradual decline in quality of health care and in employment conditions in the public sector, and an attendant lowering in the confidence of individuals in State-owned and State-operated health institutions, occurred as governments began to economize on public expenditure and the real wages and salaries of public servants began to fall behind those paid by the private sector. There was an increasing gap between public sector salaries and the cost of living. Many public sector employees responded by using public service time to engage in private enterprise; health professionals would devote only part of their time to work in public

institutions, while the remainder was spent working in private clinics. They were concerned to keep their public sector employment in order to benefit from the non-monetary advantages it offered such as subsidized housing, school fees, transportation costs, pension benefits and other allowances or in some instances, especially for physicians, having access to clinical and academic advances and benefit from the prestige of an official appointment.

The same services were offered by the same people moving between the public and private sectors, but the context was different. Patients were encouraged, directly or indirectly, to seek more and more services in the private sector if they had the ability to pay. Those who did not have a sufficient income would often sacrifice everything to pay for private services. Brand-name drugs were often pushed at the expense of less costly generic drugs, and the ordering of diagnostic procedures that were not entirely necessary became common practice with the increasing commercialization of health care. Patients and the wider population began to perceive a difference, real or imagined, between services, further affecting the quality of services delivered by the public sector. Public policy has so far failed to resolve these dilemmas.

- A totally private health care system has an in-built tendency to reflect the inequities that exist in all societies. Disparities in access to health care in a country reflect socioeconomic disparities resulting from its development strategies and patterns of economic growth. If market forces alone are allowed to determine the allocation of resources in a health care system, the services will be distributed according to ability to pay, thereby excluding those who cannot afford to buy the health care they need. By its very nature, the private sector in health is led by demand, and will concentrate its services in areas where purchasing power is high.

  It is at this point that the State must ensure – which does not necessarily mean provide – that health care is available to all who need it, regardless of ability to pay. The State system can and must adjust its priorities and the allocation of its resources continuously to render access to health care more equitable.

- Policy-makers face a major dilemma in deciding whether to allocate a part of the health care system to the market, and in choosing which part, and how it would function. There are a multitude of options that combine public and private delivery of health care and services. What is important is a clear recognition of how the values that guide an equity-oriented public sector differ

from those that guide the private sector. A successful policy must be soundly orchestrated to ensure adequate allocation of resources to the public sector and setting of appropriate standards and mechanisms for regulation and monitoring of the private sector, in order to maximize the benefits that can be derived from mixed systems.

The consequences of inequity

The failure of macroeconomic policies and the free-market system to ensure equitable distribution of wealth has led to an active process of poverty creation. Not only have poor people remained poor, but so have large numbers of poor nations. The vulnerable populations in urban areas have continued to increase. The proportion of the total population living in urban areas in the poorest countries, excluding China and India, rose from 14% to 25% during the period 1965-1989, producing pockets of deprivation and subhuman living conditions that are sometimes worse than those in rural areas. The poor have been portrayed as a net burden on the process of growth.

Insanitary living conditions are associated with very high rates of parasitic and diarrhoeal diseases, and with a high incidence of other communicable diseases. In some parts of the world, increasing impoverishment over the past decade has been reflected in the re-emergence of major diseases previously thought to be under effective control or to have been eradicated.

The incidence of cholera, for example, is directly associated with inadequate housing, and lack of clean water and sanitation, and has increased dramatically in the past 10 years. Tuberculosis is re-emerging as a major disease in areas of poverty in industrialized and developing countries alike. In some areas, the spread of tuberculosis is being exacerbated by AIDS and *vice versa*.

Extreme and widespread poverty, persistent high unemployment and the forces leading to social disintegration are perceived as the most evident sign of the deep-seated social crisis that almost all societies face today.

This is illustrated by HIV infection which follows existing fault-lines in society. Poverty exacerbates the spread of HIV, particularly where women and men, girls and boys, are forced into prostitution through economic necessity. Similarly, economic and social pressures all too

often lead to the use of drugs and to the consequent risk of HIV infection from contaminated needles. Children forced through poverty and family breakdown to make a precarious living on city streets are particularly vulnerable to these risks, and are an increasingly familiar sight in many countries.

The destructive repercussions of ill-health on development are tragically illustrated by the HIV/AIDS pandemic which highlights the interrelatedness of poverty, inequity and social disintegration. As young and middle-aged adults – men and women who are the mainstay of the family, the backbone of the workforce and the key to human development – die from AIDS, the profile of the workforce will change drastically. What hope is there in parts of the world where the creativity and productivity of the younger generation, upon which all economic and social progress depends, is destroyed?

Profit-led industries and employers have often ignored minimum standards of safety with disastrous consequences for employees and the community. The poor are particularly vulnerable to these occupational and environmental health risks, whether as agricultural workers in contact with old and new agrochemicals, urban dwellers exposed to environmental pollution, or as child labourers. Accidents and man-made disasters have grown in scale and intensity and have become one of the leading causes of death and disability.

The experience of health care vividly demonstrates that what is profitable is not always what is good, and that those who need health care most are often those who cannot pay for it. Who are those people who cannot pay? We all know them: the marginalized, the disadvantaged and the vulnerable who do not fully participate in the social process. It is in the area of health that their vulnerability is most apparent.

How much would a society save by investing in preventive measures against poor nutritional status? Savings would be gained not only from a reduced need for institutional care, but also in terms of costs that cannot be measured in monetary terms, such as suffering of the individual affected, the family, care-providers and the community as a whole.

The case of women

There is perhaps no single group that illustrates better the combined impact of poverty, unemployment and social disintegration on health and quality of life than women. The poor health status of women has disastrous repercussions for economic development. It is estimated that women are the sole bread-winners in one-quarter to one-third of the world's households, and in many parts of the world women are an integral and essential part of the labour force. Women account for more than 70% of the agricultural workforce in many parts of Africa. In these situations, the economic cost of the low health status of women in terms of lost productivity is particularly high, and the diminished ability of those who are mothers to provide adequate care and support for their children is also a problem.

There is no doubt that women's overall health has improved. This is illustrated by the generally increased life expectancy of women. But has there been a corresponding improvement in the quality of women's lives? Women who reach old age must frequently contend with loneliness, alienation, disability and poverty.

Girls are born with a biological advantage over boys, but this is often cancelled out by the social disadvantages they suffer. Differential feeding practices, additional burdens of work as compared with men and lack of basic schooling for girls put them at greater risk of malnutrition and disease. Early pregnancies (before girls reach physical and social maturity) set a pattern for repeated pregnancies and pose a major risk to their lives.

One of today's tragedies is the persistent denial of education to many girls and women, and the relationship this has to disease and health conditions that affect them. Illiteracy and the denial to women of information pertinent to an understanding of how their bodies function, and how they can prevent disease and protect themselves, often leads to harmful practices being perpetrated by women themselves. Some of these health-damaging behavioural patterns extend from childhood to old age and include food taboos at various stages in the life of a girl or woman, harmful practices during pregnancy, delivery and care of the new-born, introduction of harmful substances into the vagina, female genital mutilation, and many more.

The unprecedented scale on which political, economic, social and technological changes are occurring affects the health status and

quality of life of both men and women, but it has particular health consequences for women because of their biology, physiology and social conditioning.

In many political arenas democratization has opened new avenues for women's advancement and has contributed to political and legal gains for women. Women's empowerment has opened the door to their active participation at all levels of decision-making – including a greater say in the restructuring of society and in efforts to eliminate discrimination, foster equality and enhance health. The exclusion of women is most apparent in countries where democratization has not yet begun, but in many countries where democracy is nascent or established there may still be fundamental contradictions. While democracy opens up prospects for equal opportunity for men and women, it does not necessarily provide the mechanisms for effective expression of this equality, nor does it address the underlying roots of discrimination that may continue to flourish in democratic systems. In these situations women may have very little say in decisions regarding their health needs and the type of health services they require. Such services must be economically and culturally acceptable.

In the economic and social domain, the forms of adjustment that are most conducive to growth and protection of human needs will not be made by accident. They have to be encouraged by appropriate incentives and policies and will also require political courage. In spite of broad recognition of this imperative, the most vulnerable women still find that their needs remain unmet and that little has been done to mitigate the social costs of economic adjustment on their lives.

In a highly competitive climate where there is emphasis on the production of cheap tradeable goods, many companies seek to produce these goods at the lowest possible cost by increasing working hours, by sacrificing costly safety standards and by cutting wages. Women fill the ranks of these low-paid workers. The health consequences can be seen when numerous workers lose their jobs in massive lay-offs, or suffer acute or chronic ill-health due to poor working conditions.

Technological innovations in health care have not benefited all people equally. The available technologies may be inappropriate or may not respond fully to women's health needs. Consequently, women receive fewer intensive diagnostic and treatment interventions than men, especially in the case of cardiovascular conditions.

Women have not been sufficiently involved in the development of technology.

Women may also be given insufficient access to existing methods for disease prevention. For example, women often lack the means to protect themselves independently against sexually transmitted diseases (STDs) and other conditions.

It has been stressed that adequate nutritional intake is important for all human beings and that malnutrition is closely linked to patterns of morbidity and mortality. However, good nutrition is particularly important for girls and women. This is because of intergenerational and cumulative effects which permeate different phases of a woman's life as well as transmitting the effects of deficiencies to their offsprings.

Women must cope with social stress and pressure in a personal way but, as mothers, wives, daughters, sisters and care-givers, they must often bear the extra burden of coping with the unemployment of a husband or a child, the drug abuse of a brother or the rape of a daughter.

The cost of conflict and violence

In recent decades humanity has avoided wars on the scale of the First and Second World Wars, but smaller and more persistent military conflicts and civil wars have become endemic in many parts of the world. As a result, there has been a pervasive militarization of societies which, while in some instances necessary for national defence, jeopardizes the democratic process.

Relatively easy access to ever more sophisticated weapons of destruction has allowed the levels of violence in societies to escalate. New structures of violence, born out of the overwhelming temptation of quick and easy access to huge fortunes, have emerged, such as transnational criminal organizations engaged in illegal trade in narcotics, arms and other goods. International terrorist networks have grown up and pose major threats to the security of States and to the lives of civilians.

The increase in violence worldwide is one of the most glaring results of conflict and social disintegration related to poverty and unemployment. Violence is a public health issue. Indeed it is one of the most

complex problems that the public health field has ever addressed, for there is no single cause nor any one solution. Violence may erupt as a result of structural factors, such as patterns of economic, political and social domination; it may express the anguish of those who see no future reward for their efforts, or of those for whom the future seems bleaker than the present; it may be due to traumatic experiences suffered in the home or community, or to any situation marked by cruelty, discrimination, rejection, or forcible and arbitrary domination.

While it is widely accepted today that there is no single direct relationship between poverty and violence, a close association does exist between inequity and violence. It is not that poor people are intrinsically more violent than other members of society, but rather that the inequities they suffer, combined with disempowerment, fear, insecurity, frustration and the depression these cause, are contributing factors to violent behaviour.

The frequent association of violence with drug or alcohol use should also be recognized. This has often led to the corruption of social values and even of institutions such as the judicial system. A violent culture transmits the values that sustain it – in the family, at school, in the arts or in the mass communication media.

Violence associated with gender, ethnic differences, family relationships or sexual preference may invade areas of privacy that could otherwise provide a safe haven from outside aggression, turning them into settings for domination and cruelty.

Violence towards children, and the degree to which violent images are permitted to permeate film and other media, can be regarded as a reflection of the level of violence tolerated by a society. Gratuitous violence on television is on the increase, at a time when this means of communication often acts as surrogate baby-sitter. In some countries, it is estimated that when a child leaves elementary school, he or she will have witnessed 8000 murders and 100 000 acts of violence on film. Violence thus becomes normal.

Violence draws off resources from the health care systems of all nations urgently needed for the treatment of other health problems. For example, in one industrialized country, medical costs due to firearm injuries exceed $1 billion per year. In the same country, domestic violence results in almost 100 000 days of hospitalization,

around 30 000 emergency department visits and 40 000 visits to physicians each year. Nearly three out of four crimes result in economic loss and 10% of all victims of violent crime need time off work. Injuries caused by violence result in direct health care costs which are estimated at $5.7 billion per year; and for every death from violence, there are more than 100 times as many non-fatal injuries.

To these financial costs must be added the costs associated with the atmosphere of insecurity and fear that arises from a violent environment. Demands for more and better law enforcement, police and military forces divert resources from more socially oriented strategies. The costs of private surveillance and weaponry have an impact on a country's economy and syphon off funds that could have been used for preventive health programmes. Studies are currently underway to analyse the correlation between cuts in health budgets and increased expenditure on policing, security and prisons. Processes of social disintegration are often at the root of political conflicts and find their most acute manifestations in collective group violence of various types and in civil war.

The health costs of such conflict and aggression are incalculable in terms of mortality and disability. The injuries inflicted by modern weapons demand resources, for example, equipment and skilled personnel, which are far beyond the reach of many countries. The use of landmines has consequences that extend beyond warfare, with a devastating impact on the life of the civilian community and on the economy: a $1 landmine costs between $300 and $1000 to clear when the conflict or war is over. Conflict not only leads to death and mutilation from fighting, but also to vulnerability to the spread of disease, particularly among people fleeing from fighting and among the communities that grant them refuge. Other consequences may include the destruction of the health infrastructure, or the pollution of water that leads to epidemics which are difficult to contain in situations of conflict.

The rehabilitation of war victims is an additional social and economic burden. Many war victims never recover; large numbers are unable to resettle in their communities and many will be permanently handicapped. The total health cost of these mental and physical traumas may never be measurable.

Local wars and human rights abuses have fuelled the refugee crisis. Given that the total number of people forcibly uprooted during the entire 20th century, including the two world wars, is estimated to be around 140 million, the trend of the past decade seems to be unprecedented. The health consequences of the refugee crisis are likely to be long-term and may pass from one generation to the next.

The changing character of WHO's response

In reflecting on crucial questions with regard to the past, current and future scenarios for global health leadership, the Task Force observed that whilst WHO's mandate provided it with a most unique opportunity to exercise this leadership and to enjoy an outstanding association with the scientific community, it still rested to a certain degree on its past achievements.

From its inception, the World Health Organization, as the global intergovernmental organization in the field of health, has endeavoured to fulfil the need for international cooperation in four vital areas.

1. It has performed an essential function in organizing and enhancing the global stock of knowledge about health for the benefit of humanity as a whole; this required the gathering, processing and sharing of available knowledge, and the generation of new knowledge on a global scale.
2. It has provided the means for collective and concerted action by governments on existing and new health hazards which are transmitted in various ways from one country to another. This has required the surveillance and protection of human health across national boundaries, the setting of standards and ensuring their observance.
3. It has addressed the urgent health needs of populations in developing countries in which the disease burden was much greater, and people's chances of survival were much lower, than in developed countries. This involved a wide-ranging scientific effort to solve disease problems specific to developing countries and enabling the transfer of knowledge and technology to enhance their capability for their own health care. It also included human resource development for health on a large scale.

4. It has developed and upheld the global ethic in health. In the mid-1970s, WHO reached an historic milestone in its evolution. Its international experience in health had progressively defined its role as the world's conscience in health. These concerns came to dominate WHO's agenda during this period and eventually found expression in its commitment to the Global Strategy for Health for All.

WHO's achievement in the first three areas was considerable when the focus was on clearly identifiable problems of health care. This emphasis was intrinsic to the priorities it addressed in the first quarter-century of its work. The expectations of policy-makers were directed towards the visible and quantifiable benefits of controlling diseases which were rampant in their countries and of reducing high rates of mortality. There was no requirement for studies of the socioeconomic determinants of health and the evolving epidemiological transition. WHO was therefore unable to make much headway in dealing with the interface between health and the development process, nor with the provision of guidance on the policy responses and the capacity-building that were needed. Likewise its attention to the value systems and norms in health was selective and ad hoc. Despite valuable contributions to specific projects such as those for reducing tobacco use and encouraging breast-feeding, WHO was not able to extend this effort and assume a more effective role as the global conscience in health.

The changing global scenario in health and development processes and the expansion of human capability and choice have brought with them new risks, as well as opportunities for better health. Consequently, the frontiers of health security and accountability for health have moved into new territory where the health sector is weak. The nature of the tasks and the challenges facing WHO have changed dramatically over the last two decades and so have the range and nature of the functions it must perform. WHO's capacity, both within the Organization and in the global systems it has created, has not kept pace with the changes, leaving it struggling to manage some of the major global health issues that have emerged.

The World Health Organization was and is governed by its Member States which decide together on global health policies and their implementation. Member States were supported in this function by WHO's Secretariat, which was charged with priority-setting and carrying out, in partnership with countries, the policies and actions

formulated. However, in recent years as the resource capacity, and sometimes the will of many Member States to implement the global policies they had formulated decreased, the Secretariat's traditional role has seemed less relevant and its impact less measurable.

Another change has been the increasing influence on setting of priorities for specific WHO programmes by providers of extrabudgetary resources. This explains why much of the criticism directed at WHO has focused on its Secretariat, and why less attention has been given to implementation at the country level of policies collectively formulated by the Organization, and their relevance and adequacy in responding to the real health priorities of countries.

A further qualitative change has occurred in the character of the Organization's executive organ. The experts in public health on this technical body were designated by a rotating participation of Member States, and were charged with bringing their expertise to bear in debating and making recommendations for the work of the Organization based on the most up-to-date scientific information and knowledge. These recommendations on strategies, priority activities, resource requirements and distribution would then be taken into consideration by the World Health Assembly, the supreme policy organ of the Organization. Sadly, the Organization has suffered from increasing political pressure which often translates into the views of countries or regions, rather than those of individuals acting in their personal capacity, coming from its executive organ.

The membership of WHO must agree on accountability for translating the global commitments of the Organization as a whole into national health systems and on a process of regular monitoring, evaluation and reporting to a global entity. If such a global framework of values and norms were to be consistently accepted in the field of health, this would enable WHO to make considered interventions and to take meaningful initiatives in areas which are vital to public health, but in which, hitherto, it has had to remain a passive observer. These include, for example, the international trade in narcotics, violence in society and the new pathological forms in which it is manifested, the role of health in conflict resolution and peace, and processes of brutalization in prevailing prison regimes.

Part II
Our legacy for the 21st century

In reflecting upon the consequences of WHO being replaced, recast, or even disappearing, it is our belief that a reinvigorated World Health Organization would be imperative for protecting, promoting and defending the need for improved health status as a prerequisite to human development. Future generations will judge us by the extent to which we have been able to recast the Organization's mission and role, and from the relevance of its actions on the international scene. As we have already mentioned, the world has changed considerably since the time of WHO's founding, and is in a state of constant evolution. This is why the solution to the problem of strengthening WHO's global leadership role is complex and cannot be found using only existing strategies.

The manner in which society considers the health and development of each and every person, and the realization of each person's health potential as an essential attribute of human development, will depend to a certain extent on WHO's ability to exercise its responsibility in global health leadership. Ensuring that health security for all is regarded as a significant contributor to social cohesion, peace and a better quality of life will necessitate a partnership between the health sector and other sectors of society. In pursuing their efforts, WHO and these partners will ensure that health security becomes a reality.

Setting a global health agenda

WHO should act as a catalyst in health policy-making and promote the establishment and implementation of a strong global agenda for health with and through a worldwide network of partners from both the public and private spheres.

The setting of this global health agenda and policy will require the use of relevant scientific knowledge and information. For instance, it will require the examination of the most up-to-date information on the health situation in all regions of the world. WHO must also undertake a continuous analysis of health determinants; human health must be considered in its total environment: physical, biological, social, political, economic and cultural. This analysis will

strengthen the ability to set priorities which meet the needs of countries and of people.

WHO, together with its Member States, its collaborating centres, institutions and partners, must be a key player in the development of a system for the delivery of health knowledge and information on the changing global health situation. Providing an authenticated and reliable flow of information must be a high priority in the public health agenda. Today's rapid advances in information technology have facilitated access to health information and knowledge. This has had several effects on our societies: first, organized bodies of expert knowledge have become accessible to individuals through computer networks and the media, and information of high professional quality is purveyed to the public. Second, there is a vast output of literature of varying reliability which discusses health problems and is addressed to popular audiences. Finally, there is a flow of health-related information such as that contained in commercial advertisements, which can have a negative effect on people's health and their lifestyles. Under these circumstances, WHO has the responsibility, together with its partners at the international, regional and national levels, to provide the environment of knowledge and information in which the public and individuals can make informed health choices.

Research, scientific knowledge and the development of technology related to human physiology, diseases, disabilities and well-being, as well as the outcomes of monitoring the extent to which population-based care is addressing the needs of all people, are key elements for the formulation of the global health agenda.

Uncertainties and imperfections are inherent in scientific knowledge concerning human health and they directly affect the quality of people's lives. Scientific inquiry adds continuously to our knowledge of the health effects of behaviour as well as of the efficacy and hazards of medical technology. Sometimes practices and recommendations, that have been accepted and applied, are later discovered to be hazardous to health. In other situations, the answers to specific health problems are subject to a considerable degree of scientific dispute and controversy. In yet other cases, uncertainty prevails regarding the right choice of treatment and care. In all these situations, the quality of health care and health security depend on the nature of information available both to the individual and to the entire health care system, and also on the way in which the inevitable uncertainties are managed by the health care system. WHO must

promote the scientific inquiry necessary to assure a sound basis for health action.

Finally, WHO should take a closer look at what enables capacity-building in countries in order to adapt the agenda to their needs. The examination of the outcomes of different health scenarios in the development process will provide important guidelines for strategic planning initiatives in both the public and private sectors, and will also be used to defend and uphold health and support the implementation of the agenda on the political scene. In particular, WHO will respond to all the major challenges of designing health systems by systematically gathering experience and knowledge from the wide range of models available from various countries. It should provide global mechanisms for the regular evaluation of various options, thereby making knowledge of best practice more readily accessible to Member States.

All these elements in hand, WHO and its partners will promote a solidly-based global health agenda on the basis of which countries can make appropriate choices.

WHO, the world's health guardian

In the 21st century we must find the courage to determine common positions on major issues for the protection and promotion of human health. WHO must act to gain global consensus and national acceptance for codes of conduct and norms that must guide the protection of health in international relations, in the use of scientific advances in national development and in the delivery of health care. This means that WHO's work and its efforts in preventing disease and protecting health must be driven by sound evidence that informs political and economic action.

The distinction between political decisions and technical and scientific ones is frequently artificial and has often led to a lack of codes of conduct on issues that have had a major bearing on human health and suffering. One of the most glaring examples is the paradox of, on the one hand, investing in control of the spread of harmful pathogens, particularly viruses, and in doing so sometimes even eradicating these diseases, whilst on the other hand, allowing the preservation of pathogens that are potential weapons for mass destruction. Another example is the way in which our societies, often

through the need to ensure a supply of essential foreign currency through tourism, turn a blind eye to prostitution and modern forms of slavery and the risk that this poses to the lives and health of their women, girls and children.

WHO together with its network of partners, and in particular the NGO community, must play an increasing role in developing codes of ethics, by documenting, alerting, forecasting and denouncing the consequences of violence, conflict and war on human health and suffering. This central role is indispensable to spare future generations from the man-made disasters witnessed during this past century.

New dimensions of health surveillance

To support such efforts, WHO must substantially expand its role in the area of health accountability. At the international level WHO will need to respond to the changing configuration of health hazards and health needs with a global health watch that incorporates new dimensions. A worldwide system of health surveillance has been one of WHO's traditional roles. This activity has so far been directed mainly to the threat of epidemics and the high incidence and endemic prevalence of certain diseases in various parts of the world. In future, WHO's global surveillance role requires much more attention to man-made hazards and promoting effective national systems for monitoring them. It must also adjust to the shifting priorities in the disease burden as non-communicable diseases, long-term disability and mental health become increasingly important features of human health profiles.

The responsibility for WHO's health watch must be shared by partners from all sectors of society. The accountability for health hazards is often made difficult by the exchange of goods and services in international trade. Therefore, it is necessary to establish forms of international cooperation which ensure systems of regular reporting from the national to the international level. WHO must be able to provide the scientific and technical support necessary to enable countries to enhance their capacities to develop and manage such systems of surveillance and decision-making to safeguard human health from the ever-increasing flow of health hazards that arise from development activities within countries, as well as through international trade. Initially, the task of defining the domain of health surveillance in this area is fraught with many complex technical

problems. It is not easy to determine priorities for this task because of the innumerable hazards of varying severity that are inevitable in the process of change. The identification of the hazards themselves as an invariable requirement of development activity would require time-consuming scientific effort. Decisions on safety limits for health purposes are often subject to doubt and controversy and, so far, the experience of countries in their efforts to enforce controls for the protection of the environment has not been encouraging. Controls which are open to litigation have been subject to processes which cause long delay and reduce their effectiveness.

WHO must also be able to motivate countries to cooperate globally to minimize health hazards and to agree on international codes of conduct and regulatory mechanisms for this purpose. Many of these modalities have been developed by the international community for the control of emissions and pollutants which endanger the ecosystem as a whole, and most countries have developed systems for their surveillance and control.

Health as a human right

WHO's Constitution clearly recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. As part of the obligations of their membership, Member States accept the duty to protect and ensure enjoyment of this right for all. However, in spite of its constitutional mandate, this is undoubtedly one of WHO's weakest areas.

The needs are three-fold. First, WHO must adopt a proactive approach to ensuring respect for the right to health so as to ensure lifelong health security for all. Second, it must promote equity as a basis for health, and ensure action to redress the underlying inequities in our societies which lead to increased risk of morbidity and mortality. Third, WHO must address the specific physical and mental health consequences of violations of human rights, and promote partnerships between the health and human rights actors.

While the International Labour Organisation has utilized its constitutional mandate to develop coherent regulations elaborating the right to work, no such progress has been made in identifying the contents of the right to health and the corresponding obligations of States. WHO's lack of leadership in the this area is disappointing because it both reduces the efficacy of existing human rights provi-

sions, and inhibits the evolution of more elaborate international standards.

Despite the fact that international legal texts recognize and protect the right of everyone to the highest attainable standard of physical and mental health, the content of these obligations, and the action to be taken by States, remains ill-defined. WHO should therefore articulate more fully the content of health rights and obligations, and identify the strategies necessary for their implementation. This is an essential component of a strategy to ensure that every man, woman and child may experience lifelong health security.

We consider health security to be of paramount importance for the coming millennium and WHO's role in this regard will be critical. The Organization must take immediate action to launch a sound programme protecting health rights and ensuring the inclusion of the protection and implementation of the right to health in the work of its partners.

Globally, the ethics of health must go beyond an approach centred on the individual and his or her rights and consider the broader needs of the community.

To make its renewed commitment to Health-For-All effective as one of the governing principles of development, WHO would need to organize a global network on equity and development comprising groups of scientists from relevant disciplines, scholarly institutions and NGOs. This network would have a continuing impact on policy both at the global and national level if it worked towards a universal ethic of protection and promotion of health status, advancing the argument of the intrinsic value of health in and for itself including:

- respect for the rights and dignity of all human beings through the protection and promotion of health status and quality of life in all circumstances;
- establishing the legal and ethical basis for protection of health and well-being, particularly in conflict situations and addressing the human rights violations associated with trafficking in human beings, modern forms of slavery, unacceptable treatment of refugees, gender discrimination, abuse of children, domestic violence and sexual abuse, etc.;
- developing a framework for ensuring health accountability at all stages and levels of the development process;

- ensuring that rapid and effective relief, including curative, preventive and rehabilitative health services, are made available to those in need in times of crisis, i.e. when early warning signals indicate that health status and well-being are being compromised; and using its capacity for information collection and analysis.

WHO's approaches to health leadership

To assure its ability to catalyze a global health agenda and act as a guardian of world health, WHO must undergo a many-faceted and continuous change process. The root causes of health problems and consequent human stress are far too diverse and embedded in social change to be consigned to the windowless compartments of insular health programmes.

Many health problems do not occur in a linear fashion, but in a complex configuration. For example, sometimes nothing more than an increase in the price of a staple food may be required to trigger off social unrest of enormous magnitude with health repercussions such as large-scale population exodus, epidemics, malnutrition and other health conditions that frequently appear on the agenda of international organizations such as WHO. A different outlook is therefore required to encourage such preventive programmes which have more than a single purpose and which require a far more integrated approach to support health in development.

WHO is an *international* organization, it must now become a truly *global* one. It is the only organization which has its entire agenda dedicated to health, and must therefore link to all partners involved in one way or another in health. In view of the place of health at the centre of human development, partnerships offering the best expertise will include civil society, governments, nongovernmental organizations, commercial companies, communities and academia.

It is important to note that the use of the term "leadership" does not imply that WHO will actually undertake *itself* all the functions required for the promotion and protection of health. Rather it asserts WHO's role in ensuring that each function *is* undertaken . *WHO leadership in the 21st century will embrace rather than replace.*

WHO should take the lead in developing a broad consensus to ensure that economic policies and development strategies do not have negative effects on health status and quality of life. WHO

should also ensure that the best technical competence and the most up-to-date scientific information in all spheres of activity (public and private sectors) are harnessed to promote both the improvement of health status in the development process, and to buttress the achievement of a global health agenda.

Centres of excellence and collaborative institutions, where countries, private sector partners, non-governmental organizations and others are linked into a vast worldwide network, would be developed to this end. WHO would have a special role to ensure that the countries most in need are fully included in this process, thus accelerating the improvement of health status and services in those countries.

Partnerships for health with NGOs and the private sector may have an important role in widening the social basis of responsibility for health, but such partnerships must never exist directly or indirectly at the expense of those most in need. WHO's fundamental premises and commitments, equity, solidarity, sustainability and universality in access to health care, must be ensured when envisaging partnerships.

The ethical basis of health and health care is not negotiable. To ensure the highest standard of ethics in health, WHO must act as a catalyst in health policy-making, and act as a moral-conscience and a "standard referee" in setting universal standards, norms and guidelines. It must continue to be the standard-setter in health. WHO should work with all relevant partners in health to develop and promote the use of standards for health. In this way all those concerned stand to gain by adhering to standards and norms. As it works in this new facilitative, catalytic mode, promoting integrated approaches to health, several new strategies are called for.

Indicators for monitoring health dimensions in development

WHO should work towards the adoption of critical health status indicators for the most disadvantaged groups in all societies to serve as benchmarks against which to measure the quality and outcome of economic policies and development strategies.

This is needed to meet the challenge facing WHO, and its national and international partners, to measure the extent to which inequities in health status and access to health care services have been reduced for disadvantaged and vulnerable groups in society. The measurements, in and for themselves, should be used nationally and internationally as the most powerful indicators of the effectiveness and

quality of development strategies; techniques for monitoring should be designed to assess whether each individual's state of health has been developed to its fullest potential. While it might be possible to develop a composite index which is the aggregate of vulnerability and disadvantage in a society, such a measure will have to be derived from other indicators designed to reflect the main characteristics of vulnerability specific to each group so that they provide the elements for the interventions needed. More empirical work is needed to demonstrate the utility of such indicators and to develop the methods and criteria for identifying the relevant groups.

Such an approach is needed to monitor progress in the realization of the plans of action formulated at major international fora during the 20th century. These include: the reduction of poverty as defined at the World Summit for Social Development; the respect of human rights as considered at the World Conference on Human Rights; the implementation of environmental policies as defined in Agenda 21 at the United Nations Conference on Environment and Development; the elimination of gender discrimination considered at the Fourth World Conference on Women; and the revised approach to addressing population issues which came to the forefront during the International Conference on Population and Development.

A strong health sector closer to people's needs

An important aspect of assuring the health sector's responsiveness to people's needs is its ability to address the ethical implications of advances in medical technology and the prospects for human health in the 21st century. These advances can have an unpredictable impact on the social and institutional foundations of society, affecting as they do human reproduction, repair and replacement of vital organs, genetic characteristics and life expectancy. WHO is the global organization which can best provide leadership and promote the international cooperation needed for developing the criteria and value systems to guide humanity in the application and use of these advances to promote health and well-being in its fullest sense – physical, mental and spiritual.

Structuring an inquiry of this kind, identifying the different constituencies that must participate and creating the global networks and partnerships for the purpose, is a task which is unprecedented in scope but it must be taken on with care, patience, and persistence.

WHO can play a catalytic role in promoting the more proactive approach which will be required from the health sector to be more in touch with the people it serves. The supply of information and knowledge to enhance individuals' capacity for healthy living is a critical component of this approach. Healthy behaviour and lifestyles are becoming the key determinants of health as non-communicable diseases and long-term disability become increasingly significant components of the total disease burden of both society and its citizens. Consequently, individuals are required to assume more control over their own primary and preventive health care than ever before. They need to have access to reliable knowledge and to appropriate technology to enable them to avoid or protect themselves from the health hazards to which they are exposed in all aspects of their lives.

Health as a bridge for peace

The Task Force on Health in Development defined the contribution which WHO could make to alleviate situations of violence, civil conflict and war. It considered WHO's unique position to uphold the inviolability of health in these extreme situations and to affirm the value of human life and health across lines of violent conflict.

In view of WHO's particular strengths, which include a strict impartiality that facilitates its honest-broker role in conflict situations, its established physical presence in almost all countries that enables it to provide up-to-date information and assessment in conflict situations, and its technical capabilities, it is our belief that WHO should intensify action in health promotive and preventive diplomacy in a coherent way.

Efforts must be made to assist health professionals in conflict situations, to promote respect for their roles, to recognize their traditional impartiality and to increase awareness of the professional codes of ethics that impose fundamental obligations on physicians, nurses and other health professionals. The use of public health tools, in particular preventive medicine and epidemiology, can also be applied to conflict prevention and resolution. WHO could play an important role in this field by further monitoring worsening health conditions to provide an early warning signal of national instability which could lead to international instability. Such information could then be used to alert the world to take measures to avert the outbreak of conflict.

WHO should also provide guidelines on safe zones in conflict and humanitarian corridors, and analyse health considerations in situations where embargoes and sanctions are being considered.

WHO should document the cost of conflict and aggression, not only in financial terms but also in terms of physical suffering, disability and mortality. Finally, the issues of post-war rehabilitation and reconstruction must not be forgotten and these issues must form an integral part of a "universal moral order". Those who have died are gone, but those who survive face pain and mental and physical suffering for the rest of their lives.

Promoting human resources development for health

Among WHO's continuing essential functions will be to identify, in all countries, centres for training and capacity-building for health which are at the forefront in offering innovative programmes for human resource development.

WHO will foster an exchange of information by acting as a clearing-house for the sharing of material and curricula in this domain between countries and encouraging the development of novel programmes.

Centres of excellence may be required in specific areas such as: science and technology, health policy, negotiation skills for health defence and health advocacy, human rights and health security, documentation and epidemiology. The test of the results of capacity-building for health will be the extent to which national centres of excellence and training institutions are linked to each other to promote direct communication between centres, programmes and individuals for distance learning, instant transfer of information and knowledge, on-line documentation and exchange of materials for human resources development.

WHO's leadership will be brought to bear when it is able to bring to the fore new areas which require further capacity-building as science and technology evolve. This is essential if all countries, including developing countries, are to benefit from global progress in communications and technology. Areas in human resources development for health which will require attention in the future are:

- human rights;
- the use of existing arms and emerging weapons of mass destruction;

- codes of ethics; and
- dealing with potential conflicts, post-conflict rehabilitation, and social reconstruction.

The problem of resources

There is no doubt that the views expressed in the previous pages will lead many to ask the inevitable question: from where will the resources come to enable WHO and its Member States to address the future agenda for health.

This is a legitimate question and one we have posed ourselves and analysed at length.

To put this issue into perspective, we began by recognizing that health is a societal issue, where promoting, protecting and maintaining positive health for all people is everyone's responsibility, rather than falling only within the domain of one sector. When health is seen in this way, it is valued in and for itself as an indispensable quality of life. The unique nature of good health and the importance of the health sector can thereby be appreciated. Health would no longer be reduced to a commodity like any other, and the health sector would no longer be seen as merely a consumption sector.

Once this conviction is established, society itself will bring new light to bear on resource issues and priority setting for a stronger society.

- Society will question whether or not sufficient investment is being made in preventive measures which reap so many returns, not only in cost savings, but in the saving of so many lives and so much suffering.
- Society will begin to demand that greater investments be made in controlling health risk factors in the total environment, and in maximizing positive health determinants.
- Society will turn naturally to new and innovative ways of creating resources for health, and of diverting more resources to health by exploring a wide range of economic platforms and new partnerships.

The possibilities are limited only by the imagination in what will be a challenging and uplifting experience for those societies which will dare to go further for health. WHO must be there to support them in this effort.

PART III
Profiles of members of the Task Force

The Honourable Branford M. Taitt

The Hon. Branford M. Taitt is a Member of Parliament in Barbados and was formerly Minister of Foreign Affairs of Barbados. Prior to his appointment to this position in 1993, he was the Minister of Health, a position he held for six years. He was elected Chairman of the XXIII Pan American Sanitary Conference in 1990.

Mr Taitt, who trained as a journalist, began his career as a public servant with the United Nations Secretariat in 1962. From 1967 to 1971 he served as Barbados Consul-General in New York. He was a member of his country's first delegation to the United Nations General Assembly. Since 1971, Mr Taitt has been a member of the Barbados Parliament, and has held various Ministerial portfolios besides those of Health and Foreign Affairs. In addition, Mr Taitt is a distinguished and well-respected academic in Barbados and abroad. He has held the posts of Visiting Senior Lecturer in Law at the University of the West Indies, Distinguished Visiting Professor at Drexel University, Philadelphia and has been a guest lecturer at several universities in the United States, including Yale. Mr Taitt has also published many articles in journals, newspapers and periodicals.

Dr Huguette Labelle

Dr Huguette Labelle has been President of the Canadian International Development Agency since 1993. She is also currently Chancellor of the University of Ottawa, and a member of several Boards of Directors of organizations such as the International Centre for Human Rights and Democratic Development and the International Institute for Sustainable Development.

Prior to her current appointment, Dr Labelle held many diverse senior positions in both the private and public

sector. In the private sector, her positions were principally in health science education and nursing education. In the public sector, Dr Labelle rose to become Chairman of the Public Service of Canada in 1985 and Deputy Minister of Transport in 1990. Dr Labelle is also a distinguished academic and holds a Doctor of Philosophy in Education as well as several honorary degrees. In 1990, she was invested as an officer of the Order of Canada, and in 1993 was awarded the Vanier Medal of the Institute of Public Administration of Canada.

Dr Jo Ivey Boufford

Dr Jo Ivey Boufford is the Principal Deputy Assistant Secretary for Health in the Public Health Service of the United States Department of Health and Human Services (HHS), and is the Member of WHO's Executive Board designated by the USA. Dr Boufford is also Clinical Associate Professor in the Departments of Pediatrics and Epidemiology and Social Medicine at the Albert Einstein College of Medicine in New York. She has also held many other high-level public service and academic positions. Dr Boufford served as Director of the King's Fund College, London, England from May 1991 to September 1993 and as President of the New York City Health and Hospitals Corporation (HHC) from December 1985 until October 1989. HHC is the largest municipal hospital system in the United States with 11 acute care hospitals, five long-term care facilities, over fifty community clinics and responsibility for the New York City Emergency Medical (ambulance) Service. She was elected to membership in the Institute of Medicine in the United States in 1992.

Internationally, Dr Boufford has led high-level bilateral projects in health with Russia, Mexico and South Africa for HHS and has also acted as a consultant to, for example, the European Commission's PHARE Projects in Romania and the Czech and Slovak Republics, and the Brookdale Health Policy Center in Israel. In addition, Dr Boufford has written, co-authored and published books and articles on health policy and management, women and children's health, and AIDS.

Mr Göran Dahlgren

Mr Göran Dahlgren is Assistant Director-General of the National Institute of Public Health in Sweden. Throughout his career Mr Dahlgren has been involved in the areas of public health and social welfare. He has held appointments overseas such as Coordinator of Rural Development programmes with the Minis-try of Education in Ethiopia, and Senior Adviser to the Ministry of Health in Kenya, as well as short-term assignments with WHO.

In Sweden, Mr Dahlgren has been Senior Adviser to the Director-General of the Swedish International Development Authority (SIDA), and Assistant Under-Secretary of State at the Ministry of Health and Social Welfare. He has also conducted research on health and social welfare issues and has written and published widely on policies and strategies to promote equity in health.

H.E. Mr Assane Diop

H.E. Mr Assane Diop is Minister of Labour and Employment in Senegal. He was previously Minister of Public Health and Social Action and is still very active in the area of health in development, both in Senegal and abroad. Mr Diop has pursued his public service career nationally and internationally. He has held positions such as Adviser to the National Institute of Studies and Action for Development and Education, Head of the International Department of the National Confederation of Senegalese Workers, and Assistant Secretary-General responsible for education and training of the Organization of African Trade Union Unity. Mr Diop has also been a delegate to the ILO for more than ten years.

In the health in development area, Mr Diop is a member of the Ministers' Working Group which stemmed from the International Conference of Ministers responsible for the welfare of handicapped persons, and was the personal representative of the President of the Republic of Senegal to the World Summit for Social Development. Mr Diop was also a member of his country's delegation to the Fourth World Conference on Women, held in Beijing in

September 1995, where he gave a keynote address at the WHO Women's Health Day panel discussion on women, health and work.

Dr Julio Frenk

Dr Julio Frenk is Executive Vice-President of the Mexican Health Foundation, a nongovernmental organization devoted to the analysis and improvement of health policies. Dr Frenk carried out his medical studies at the National University of Mexico and received a joint Ph.D. in health systems organization and in sociology from the University of Michigan.

In 1984, he began his career as the founding Director of the Centre for Public Health Research in Mexico and from 1987 to 1992 he was the founding Director General of the National Institute of Public Health in this country. Dr Frenk has carried out several research projects on medical manpower, including the education and employment of physicians; coordinated a study of the National Academy of Medicine of Mexico on the health implications of the North American Free Trade Agreement; and is currently researching the policy implications of shifts in the dominant patterns of health and disease. He recently completed a comprehensive health policy review in Mexico, which analyzed options for health system reform.

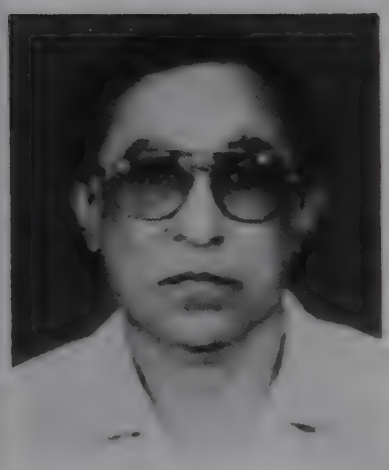
Dr Frenk belongs to several scientific and professional associations, including the United States Institute of Medicine. He has also written and published many books, monographs and articles in connection with his research. As a medical student, he published a best-selling novel for youngsters explaining the functions of the human body.

Dr Dharam Ghai

Dr Dharam Ghai is the Director of the United Nations Research Institute for Social Development. He was educated in Kenya and at Oxford and Yale Universities, receiving a Ph.D. in Economics from Yale. He has taught economics at Makerere University in Uganda, was a Visiting Research Fellow at Yale University, and Director of the

Institute for Development Studies, University of Nairobi. He was a member of the Pearson Commission Secretariat.

In 1973, Dr Ghai joined the International Labour Office as Chief of the World Employment Research Branch. He went on to become Chief of the Secretariat for the World Employment Conference of 1976, and later Coordinator of ILO's work on rural employment and development. Dr Ghai is a member of the editorial boards of several journals and of the Governing Councils of research institutes. He is also the author, co-author or editor of several books which focus on development problems such as employment, poverty, agrarian reform, rural development and the social dimensions of environment and structural adjustment.



Mr Godfrey Gunatilleke

Mr Godfrey Gunatilleke is Chairman of the Marga Institute (Sri Lanka Centre for Development Studies), which conducts an inter-disciplinary programme of social science research covering key economic, social and political problems in Sri Lanka and the Asian region. Mr Gunatilleke began his career in the Ceylon Civil Service, following his graduation from the University of Ceylon. He rose to become Director of Plan Implementation and Project Evaluation, Additional Secretary and then Special Adviser in the Ministry of Planning.

Mr Gunatilleke then embarked on an international career as a consultant to United Nations agencies such as the ILO, WHO and UNCTAD, as well as the United Nations University. He is currently a member of the boards of several governmental bodies and commissions such as the Human Resources Development Council, the Commission for the Elimination of Discrimination and Monitoring of Fundamental Rights and the National Resources, Energy and Science Authority. Mr Gunatilleke has also received many awards including the Eisenhower Fellowship USA, the WHO Health-for-All medal, and an award for distinguished service from the President of Sri Lanka, as well as receiving the honorary degree of D.Litt. by the University of Colombo, Sri Lanka. He is a member of the Board of

Trustees of the International Food Policy Research Institute in Washington. Mr Gunatilleke has written and published many works on development issues.

HRH Crown Prince El Hassan Bin Talal

HRH Crown Prince El Hassan Bin Talal of the Hashemite Kingdom of Jordan is His Majesty King Hussein of Jordan's closest political adviser, deputy and confidant as well as Regent in his absence. In order to continually improve the economic, social, and cultural life of Jordan and the Arab World, His Royal Highness has initiated and directed a number of Jordanian and international institutes and committees. In Jordan, these have included the Royal Scientific Society, the Islamic Scientific Academy, the Hashemite Aid and Relief Agency, and most recently the new Aal Al-Bait University in Mafraq.

In the international arena, His Royal Highness, in 1981, addressing the 36th Session of the United Nations General Assembly, proposed the establishment of the New International Humanitarian Order. This led, in 1983, to his founding and co-chairing the Independent Commission on International Humanitarian Issues. His Royal Highness has also initiated a series of contacts and meetings with representatives of the Orthodox Christian, Catholic and Muslim faiths which has evolved into an Interfaith Dialogue to promote understanding amongst peoples of different faiths. His Royal Highness has paid official and working visits to countries all over the world and is highly regarded. In addition, His Royal Highness has written and published numerous articles and books on political and religious issues.

Mrs Julia Häusermann

Mrs Julia Häusermann, founder and President of Rights and Humanity, the International Movement for the Promotion and Realisation of Human Rights and Responsibilities, is an international human rights lawyer and advocate. Prior to the founding of Rights and Humanity, Mrs Häusermann worked as a consultant on international

humanitarian issues with agencies such as the United Nations Relief and Works Agency, the International Council of Voluntary Agencies, and the Independent Commission on International Humanitarian Issues. As a visiting lecturer at Essex University in England, Mrs Häusermann established and taught the first master's degree course on economic, social and cultural rights. She was also instrumental in the establishment of the Jagiellonian University Centre for Human Rights in Cracow, Poland.

Mrs Häusermann writes and lectures widely, focusing on economic, social and cultural rights; the human rights implications of HIV/AIDS; human rights and development; and the rights of refugees.

The Honourable Richard C. Hove

The Honourable Richard C. Hove is the Minister of Planning in the National Economic Planning Commission of Zimbabwe, and a member of the ZANU (PF) Central Committee and Politburo. After graduating in Commerce from the University of Bombay, Mr Hove has pursued a political career. He was a founding member of ZANU (PF) and served as a ZANU representative in the United Kingdom and Western Europe in the years prior to Independence.

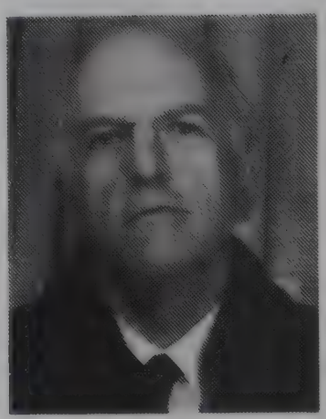
Since Independence, Mr Hove has held several ministerial posts, including those of Trade and Commerce, Mines and Defence.

H.E. Dr Jorge Jiménez de la Jara

H.E. Dr Jorge Jiménez de la Jara is the current Chilean Ambassador to Italy. Educated in Chile and in the United States in the fields of paediatrics and public health, Dr Jiménez held several medical posts before becoming an ambassador. He was also a researcher and teacher in the fields of paediatrics, respiratory diseases and public health, and was the Chilean Minister of Health from 1990 to 1992. In this capacity, Dr Jiménez launched a reform plan for the public health sector in Chile with the collaboration

of PAHO, the World Bank and the Inter-American Development Bank.

In addition, Dr Jiménez has acted as a consultant to several international agencies for health development on project preparation and evaluation in the fields of epidemiology and health services financing. Dr Jiménez has written and published many papers and books, and has contributed several articles to Chilean and international journals on social health and development issues.



The Right Honourable the Lord Judd

The Right Honourable the Lord Judd is a Member of the British House of Lords where he has been principal spokesman for the Labour Opposition on development cooperation and a spokesman on defence. He is also a consultant, specialising in international affairs, working particularly on the United Nations, the developing world, conflict resolution and arms control.

Lord Judd was from 1966 to 1979 a member of the House of Commons and served consecutively as Parliamentary Under-Secretary of State for Defence, Minister for Overseas Development and Minister of State at the Foreign and Commonwealth Office where he was deputy to the Secretary of State. More recently, Lord Judd was Director of Voluntary Service Overseas (1980-85) and Director of Oxfam (1985-91).

H.E. Professor Emilia Kováčová

H.E. Professor Emilia Kováčová is an economist and a university professor in Bratislava in the Slovak Republic. She is also the First Lady of the Slovak Republic. Mrs Kováčová began her career as a university teacher at the University of Economics where she became a member of the National Economic Planning Department of the National Economics Faculty in 1961. Mrs Kováčová later joined the Department of Social Development and Labour of the same University and in 1991 was named professor. Mrs Kováčová is a well-known spokesperson for the rights

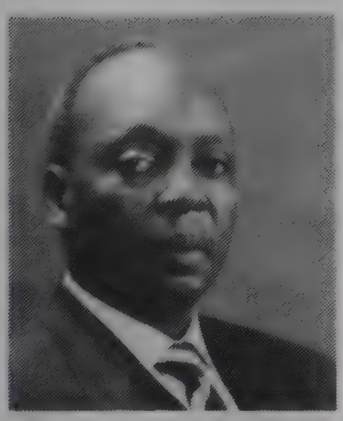
of children in the Slovak Republic. To help and strengthen charity to ease the lives of children and old people with special needs and their families, and also of socially dependent citizens; to intensify the ethical quality of education for children and the younger generation, Mrs Kováčová established the Emilia Kováčová Foundation in the Slovak Republic. During the last four years, she visited dozens of social care institutions for both children and adults with disabilities, and families with ill members in all regions of Slovakia. Mrs Kováčová is honorary President of the Slovak Red Cross. In May 1996 she was the keynote speaker on the Fourth International Congress on serving children with disabilities in the community, which was held in Washington, D.C.

In addition, Mrs Kováčová has undertaken much academic research and has published independent scholarly publications, university handbooks, many articles in professional journals, and co-authored a university textbook. She is a member of the International Steering Committee for the economic development of rural women.

Mrs Anne-Marie Lizin

Mrs Anne-Marie Lizin is a Senator in the Belgian Parliament, a member of the European Parliament, and a Visiting Professor at the International Relations Faculty of the University of Liège. Mrs Lizin began her career as an adviser in the office of the Minister of Economic Affairs. Since then, she has been involved in the areas of human rights, the rights of women and children, and public health and development. As a member of the Belgian Parliament, she serves on bodies such as the Commission on Finances, the Commission on Economic Affairs, the Committee of Opinion on European Questions, and the Parliamentary Assembly of the CSCP which specialises in questions of human rights. She is also a member of the Commission for Energy and the Economic and Monetary Commission, and was formerly a member of the Political Commission on Human Rights. Mrs Lizin has also served on missions to monitor elections and constitutional referenda in Nicaragua, Chile and the former Yugoslavia.

Nearer to home, Mrs Lizin is very active in her own community, being Mayor of the Town of Huy, and President of the Chateau Vert Home for Handicapped Children in Huy. Mrs Lizin has also written several books and papers on social and economic development issues as well as on human rights issues.



H.E. Dr Pascoal M. Mocumbi

H.E. Dr Pascoal M. Mocumbi, Prime Minister of the Republic of Mozambique, was born in Maputo in 1941 and, after primary and secondary education in his country, studied medicine at the Universities of Lisbon, Poitiers and Lausanne. He received his medical degree from Lausanne in 1973, after which he undertook clinical activities in various Swiss and Mozambican hospitals.

He is the author or co-author of scientific publications in the fields of obstetrics, health planning and public health. A founder member of the National Union of Mozambican Students, he was a delegate to the founding Congress of the Front for the Liberation of Mozambique (FRELIMO), and subsequently headed its Information and Propaganda Department. He served as his country's Minister of Health from 1980 to 1987, and thereafter as Minister of Foreign Affairs until 1994. In that capacity, he assisted President Chissano in promoting Mozambique's relations with other countries and in furthering the peace process in his own country. He was appointed Prime Minister in December 1994.

H.E. Mrs Suzanne Mubarak

H.E. Mrs Suzanne Mubarak, spouse of the President of the Arab Republic of Egypt, is an outstanding activist on social issues. On the national level, Mrs Mubarak founded and presides over several governmental and nongovernmental entities and associations for community development, such as the National Council on Motherhood and Development, the Egyptian National Women's Committee, the Egyptian Society for Childhood and Development, and the Integrated Care Society. Mrs Mubarak is also President of the Egyptian Red Crescent Society.

On the international level, Mrs Mubarak has led Egyptian delegations and given keynote speeches at numerous international, United Nations, and other conferences on social issues such as childhood, women, health, education, and family planning. These conferences have included the World Summit on Children (New York, September 1990), the Summit Conference on Rural Women (Geneva, February 1992), the International Conference on Population and Development (Cairo, September 1994) and the Fourth World Conference on Women (Beijing, September 1995). In 1994, Mrs Mubarak was awarded the Health-for-All Gold Medal, WHO's highest distinction, in recognition of her unique contribution to improving the quality of life of women and children in Egypt and her personal commitment to international efforts aimed at integrating health in the development process.

Mrs Ana Milena Muñoz de Gaviria

Mrs Ana Milena Muñoz de Gaviria is an economist. As First Lady of the Republic of Colombia (1990-1994), she worked to promote better conditions for the more vulnerable groups such as children, women, youth, the elderly and indigenous groups. In particular, Mrs Muñoz de Gaviria supported the development of the National Plan of Action which was defined at the UNICEF Children's Summit (1990), the formulation and implementation of the National Policy for Youth and Women, and the design of community-based programmes in the areas of health, culture, and income generation. Other projects include the development of human resource capacities, information systems, as well as the formulation of legislation on, and the raising of public awareness of, the health needs of underprivileged groups.

She has been instrumental in promoting cooperation between governmental and nongovernmental organizations, and in promoting women's issues at many international events. These have included, in particular, the Summit on the Economic Advancement of Rural Women in 1992, and the annual meetings of First Ladies of Latin America and the Caribbean.

H.E. Mrs Janet Museveni

H.E. Mrs Janet Museveni is the wife of the President of Uganda and founder of the Uganda Women's Effort to Save the Orphans, a non-political, non-profit and non-denominational organization with the sole purpose of caring for orphans and destitute children. She is also a political activist who spent many years at home and in exile supporting her husband in the fight for peace and democracy for Uganda. On her husband's accession to the Presidency, Mrs Museveni began her work to improve social and health conditions for ordinary Ugandans.

Besides establishing the Organization to save the orphans and destitute children, Mrs Museveni has set up NGOs specifically to deal with women-related problems, e.g. Women International Maternity Aid (WIMA) for maternal health, The National Strategy for the Advancement of Rural Women in Uganda (NSARWU) committed for economic empowerment of rural women and solving other rural related problems affecting women. She is also involved with youth work, both at national and international levels, and many activities and community development programmes for women, and has instituted AIDS Control Programmes. In February 1996, Mrs Museveni became Chief Patron to "Uganda's National Safe Motherhood Programme", the main objective of which is to reduce maternal and neonatal mortality and morbidity.

Mwalimu Julius K. Nyerere

Mwalimu Julius K. Nyerere, the President of the United Republic of Tanzania from 1962 to 1985, is currently the Chairman of the South Centre in Geneva. Mr Nyerere was educated at Makerere College in Uganda and Edinburgh University in Great Britain, and then returned to teaching. However, Mr Nyerere was also a political activist and, when forced to choose, gave up teaching rather than abandon his political activities.

In 1954, he became a founder member and first President of the Tanganyika African National Union (TANU). He campaigned relentlessly for independence and spoke on

behalf of TANU to the Trusteeship Council and Fourth Committee of the United Nations General Assembly in New York. In 1958, Mr Nyerere was elected as a Member of the Legislative Assembly in the first election in which Africans could vote, and then became Leader of the Opposition in Parliament. He became Prime Minister of the first Government of independent Tanganyika in 1961, and President from 1962 when Tanganyika became a republic.

Mr Nyerere continues to work for peace and unity in the international community. He has written and published many works focusing on these issues as well as development and human rights issues.

Dr Adepeju A. Olukoya

Dr Adepeju A. Olukoya is the Coordinator of the Women's Health Organization, and Associate Professor at the Institute of Child Care and Primary Care at the College of Medicine, in Lagos, Nigeria. Dr Olukoya was educated in Nigeria and in the United States and holds qualifications in Chemistry, Medicine, Education and Public Health. During her career, Dr Olukoya has been involved in every aspect of health care delivery, training and development. She has worked as a medical practitioner, medical researcher, and Consultant to Nigerian associations, and United Nations and other international organizations on primary health care and health and development issues.

Dr Olukoya is also an active member of bodies such as the National Working Group for the implementation of the Programme of Action of the International Conference on Population and Development and the Beijing Declaration and Platform for Action, and the Advisory Committee of the WHO Centre for Health Development in Kobe, Japan. She has written and published many books, monographs and articles focusing on women's sexual and reproductive health, including family planning and adolescent health in the primary health care context, and medical education.

Mr Johannes P. Pronk

Mr Johannes P. Pronk is the Minister for Development Cooperation in the Netherlands, and holds the Den Uyl Chair in the International Order at the University of Amsterdam. He began his career at the Development Programming Centre and the Netherlands Economic Institute, where he lectured in development programming and development economics, conducted research and published papers on development issues, economic planning, and aspects of the international economic order.

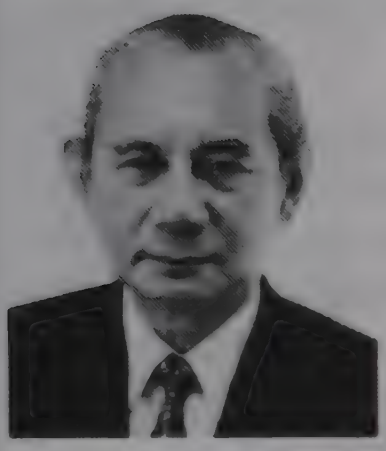
In 1971, Mr Pronk went into politics as a Labour Member of the Lower House of the Netherlands States-General and served his first term as Minister for Development Cooperation between 1973 and 1977. In 1973, he also served as a member of the European Parliament; between 1977 and 1982 as a member of the Brandt Commission; and between 1978 and 1980 lectured in development economics at the Institute of Social Studies in The Hague. Mr Pronk was then appointed Deputy Secretary-General of UNCTAD, a post he held till his return to the Lower House of the States-General in 1986.

Dr Rosalia Rodriguez-Garcia

Dr Rosalia Rodriguez-Garcia is the Chair of the Department of International Public Health at the George Washington University School of Public Health and Health Services, the co-founder and director of the Center for International Health, a World Health Organization Collaborating Center for health and development, and is a professor of international public health, medicine, and international affairs. Dr Rodriguez is a member of the Board of Directors of the National Council for International Health, and of the Human Rights Committee of the American Public Health Association. Dr Rodriguez directs academic programmes, field projects, and international cooperation agreements of the above Center for International Health, and directs the graduate academic programmes on international health and development offered by the George Washington University Elliott School of International Affairs, and the international specialties of the

Master of Public Health Programmes at Master, Certificate and Doctoral levels.

Throughout her career, Dr Rodriguez-Garcia has worked in the international health, population and development field, particularly in the areas of maternal and child health research, education and services. She has worked as a consultant to WHO, PAHO, UNFPA, UNESCO and the US Agency for International Development as well as other international and national organizations. In addition, she has written many publications focusing on health and development, behavioural issues, and the management, education, and evaluation of maternal and child health services and training programmes. She has worked in all world regions.



Dr Emil Salim

Dr Emil Salim graduated from the Faculty of Economics, University of Indonesia (FEUI) in 1959. After obtaining a PhD degree in Economics from the University of California, Berkeley, California, USA (1964), he returned to Indonesia to a teaching post at FEUI. In 1977, he was appointed Professor of Economic Development at the Faculty. He has held a number of important senior executive and cabinet positions in the New Order Government. In 1966 he served on the Team of Economic Advisers to General Soeharto, and a member of Parliament (1967-69), and the People's Consultative Council (1969-98). In 1969 he was appointed Vice Chairman of the National Planning Body (Bappenas) and in 1971 became Minister of State for the improvement of the State Apparatus. He served as Minister of Transportation, Communication and Tourism (1973-78), Minister of State for Development Supervision and the Environment (1978-83) and Minister of State for Population and the Environment (1983-93). After his retirement as minister, he returned to campus teaching at FEUI and Post Graduate Faculty at the University of Indonesia. He is active in nongovernmental organizations and chairing the Indonesian Biodiversity Foundation, the Foundation for Sustainable Development, the Working Group of the Ecolabeling Institute, and is also Vice Chair-

man of the UN High Level Advisory Board on Sustainable Development, Co-Chairman of the World Commission on Forest and Sustainable Development and Co-Chairman of the US-Indonesian Society.

Dr Conrad F. Shamlaye

Dr Conrad F. Shamlaye has been Special Adviser to the Minister of Health of the Republic of Seychelles since 1993. A graduate in medicine from the University of Glasgow, Dr Shamlaye worked as a medical officer in Scotland and the Seychelles in hospital and community health services. As part of this work, he organized community-based health and education programmes, particularly in the areas of child and adolescent health. In 1984, Dr Shamlaye qualified in epidemiology and returned to Seychelles to take charge of epidemiological and environmental health services.

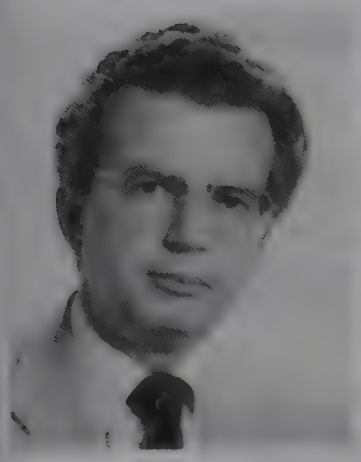
From 1986 until 1993 he served as Principal Secretary and Director of Health Services in the Ministry of Health, and actively promoted the role of health in social and economic development. He also continued to develop health programmes, carry out research, and set up the Red Cross Society of Seychelles. Dr Shamlaye is a keen student of health development in developing countries and has represented Seychelles at many international conferences where he has promoted international health cooperation, in particular in the Commonwealth Regional Health Community for East, Central and Southern Africa. In 1996 he obtained a further qualification in health economics.

Madame Simone Veil

Madame Simone Veil is one of the leading and most influential politicians in France and in Europe, and is currently the Deputy President of the European Parliament. Having survived the Nazi concentration camps of Auschwitz and Bergen-Belsen, Mme Veil went on after the war to become a lawyer and politician. She worked to further the rights of, in particular, women, adopted children, older adults and immigrants. Mme Veil held many

ministerial portfolios including those of Health, Health and Social Security, and Social, Health and Urban Affairs. She has also served as President of the Judicial Commission of the European Parliament.

Mme Veil has been honoured in her own country (where she is a Chevalier of the National Order of Merit) and many other countries, having been awarded, for example, the 1991 Truman Prize for Peace, the 1980 Prix Athènes de la Fondation Onassis, and the 1981 Prix Charlemagne. Numerous honorary doctorates have been conferred on her by distinguished universities in many parts of the world. She has written or contributed to many publications, including the well-known work "Les données psychosociologiques de l'adoption".



Mr Helmut Voigtländer

Mr Helmut Voigtländer, born in 1939 in Düsseldorf, Germany, is currently Head of International Relations and Co-operation with the European Union, and is also responsible for cooperation with developing countries in the field of health, in the German Federal Ministry of Health. He has a degree in law and medical studies in his home country, and studied political sciences at the Sorbonne in Paris.

In addition, Mr Voigtländer is a member of the German Task Force for Humanitarian Relief, a member of the Standing Committee of the WHO Regional Committee for Europe, and Chairman of the European Health Committee of the Council of Europe, a post which he also held in 1981/1982. Previously, he has twice held the presidency of the Governing Council of the International Agency for Research on Cancer, and has chaired many WHO fora, among them Committee B of the World Health Assembly and the Regional Committee of Europe. He is a member of the WHO Executive Board.

Annex 1

Resolution WHA45.24 on health and development

The Forty-fifth World Health Assembly,

Recognizing that, as stated in the WHO Constitution, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition";

Taking into consideration the Accra Initiative on Health which resulted from the International Forum on "Health: A Conditionality for Economic Development - Breaking the Cycle of Poverty and Inequity", held in Accra in December 1991, which emphasized the crucial relation between economic development and health, especially the health of vulnerable groups;

Having considered the Director-General's report on the International Forum in Accra[1] and the follow-up work, and commending him for the success of the conference and the quality of the background document;

Concerned about the intolerable health situation of the most vulnerable groups, which experience unnecessary pain and suffering from preventable diseases, economic deprivation, social isolation, violence, abuse, and war;

Recognizing that individual health status and aggregate health status indicators are significant measures of a person's and a society's overall development and productive potential;

Realizing that certain economic development policies and strategies have contributed to the creation of new vulnerable groups and have not been able to solve the whole range of health problems already confronting vulnerable populations;

Recognizing that health status is related to basic education, access to relevant information and economic productivity;

[1] See document WHO/DGO/92.1.

Realizing the urgency of integrated cost-effective health interventions with sustainable economic and development policies and strategies,

1. URGES Member States to:

(1) take the necessary measures to ensure the achievement of the goal of health for all by the year 2000;

(2) take specific steps to improve the health status of the most vulnerable population groups;

(3) analyse the health impact of existing and future development projects and implement the necessary protective measures to safeguard, promote and improve the health status of affected populations;

(4) explore the feasibility of creating, where necessary, and strengthening alternative financial arrangements for the improvement of the health status of vulnerable population groups;

2. REQUESTS the Director-General:

(1) to establish a multidisciplinary task force to undertake the following:

(a) study existing development policies, strategies and programmes throughout the world to determine which factors enhance or hinder the promotion and improvement of health status;

(b) analyse health status indicators and their relation to economic development, with emphasis on the situation of the most vulnerable groups;

(c) examine alternative funding mechanisms which would help countries evaluate the relation between health status and economic development strategies;

(d) explore ways and means of improving access to basic education, credit facilities for small industries, and other means of assisting countries to improve the health status and protect the health rights of the vulnerable groups;

(e) recommend appropriate arrangements for the protection of basic health as a human right and, in consultation with all partners concerned, initiate a process of education and consen-

sus-building to ensure that health status is protected in the development process;

(2) to disseminate the results and message of the Accra Initiative to other organizations of the United Nations system and other international agencies;

(3) to ensure that all WHO programmes identify highly vulnerable economic groups and provide the means to evaluate and improve their health status;

(4) to report to the ninety-third session of the Executive Board and the Forty-seventh World Health Assembly on the progress made in implementing this resolution.

May 1992

Annex 2

Declaration on the centrality of health in social development*

During the last 15 years, the world has witnessed a major up-heaval in the development process, affecting in particular the least developed countries and disadvantaged populations within these countries, the consequence of which is a global health crisis.

- All countries are in the process of a multi-faceted transition - economic, demographic, technological and epidemiological - in which the challenge of satisfying changing health needs and demands for health security is becoming an increasingly complex and difficult task for policy makers;
- Many countries are suffering from the harsh social impact of restructuring their economies and lack the resources to protect the health and quality of life of the most disadvantaged and marginalized groups in their societies;
- Unemployment in both developed and developing countries, mainly affecting youth newly entering the job market, is producing a configuration of health hazards related to alienation, psychological stress, drug addiction and violence, which have profoundly disturbing social consequences;
- The displacement of people and widespread social disruption caused by civil conflicts and wars in many parts of the world are having health consequences of an unprecedented and traumatic character likely to be transmitted from one generation to the next;
- Changing epidemiological profiles are creating new health problems and placing an additional burden on already overstretched health systems. The HIV/AIDS pandemic with its deadly link to tuberculosis is devastating the labour force of Africa and rapidly spreading in Asia, posing a grave threat to the development efforts of countries already in distress.

The global crisis in health reflects serious weaknesses in some of the development strategies and policies that have been pursued in the

* Text adopted on 17 February 1995 in Paris during a meeting held at the initiative of the WHO Task Force on Health in Development, and attended by personalities from both North and South, invited by Madam Simone Veil, Minister of State for Social, Health and Urban Affairs of France and member of the Task Force.

past. At the same time, the current trend towards globalization of the economic system based on an open market economy and favouring privatization has brought to the forefront a new set of critical issues concerning health in development.

- Health has to be firmly placed in the centre of the development agenda to ensure that the protection and promotion of the quality of life goes hand in hand with economic growth and technological progress. Health has to be valued as an indispensable part of the improvement in quality of life which is the aim of development. Other sectoral policies and goals should be aligned to essential health goals.
- Market forces and profit-making enterprises on their own are unlikely to ensure equitable health outcomes. There has to be a fair share of public responsibility for health guided by a caring value system based on social justice.
- Poor health produces a state of hopelessness and insecurity that not only lowers productivity but may undermine the very foundations of development. Health status, especially of vulnerable groups, should be used as one of the central indicators of development.
- Health criteria and health outcomes should be incorporated as essential components of development assistance, multilateral lending and international economic relations as a whole.

In developed countries, the increase in unemployment associated with the economic crisis is marginalizing sizeable minorities, with a resulting deterioration in their health status. Population groups coming from developing countries are generally among those hardest hit by this trend. Action needs to be taken in developed countries to devise policies that will give these population groups easier access to the health system.

The World Health Organization, in fulfilling its mandate for overseeing, coordinating and directing international health work, has recently established a Task Force on Health and Development Policies to respond to some of these critical issues. In order to avert an even deeper health crisis, the Task Force has committed itself to a wide-ranging programme of action which should contri-bute to ensuring that health considerations are accorded the necessary

priority in development policy at the global, regional and national levels. The World Summit for Social Development offers a unique opportunity to bring health into the centre of the development agenda.

Four areas of particular interest were identified which should be addressed in the World Summit for Social Development.

- ***Health as a basic human right*** is inseparable from the purpose of development and is fundamental to human well-being. It is neither a commodity nor a negotiable good that can be bought and sold for a price or traded off against economic gain. The right to health is a central objective for each country of the world and for the whole international community. It must be achieved through the establishment of policies and programmes that lead to a substantive and measurable reduction of current inequalities in health between countries and between social groups within each country.
- ***The link between health, poverty and unemployment*** encompasses the effects which exclusion from productive economic and social life has on health and quality of life. It also includes the disruptive economic and social consequences which result from conditions of ill-health often produced by poverty and unemployment.
- ***While health is an inevitable victim of conflict***, its promotion is a significant means of furthering social integration, human solidarity and a sense of community, and can be a powerful factor in building peace.
- ***Successful development*** is not the attainment of wealth and technological progress alone, unless it includes the attainment of health security for all.

Heads of State and government participating in the World Summit for Social Development may wish to ensure that the World Summit, and its outcome, clearly recognize health as central to the purpose of development, in particular with respect to the four areas described above.

Annex 3

List of selected documentation related to the work of the Task Force on Health in Development

Constitution of the World Health Organization. Date of adoption: 22 July 1946. Date of entry into force: 7 April 1948.

Intersectoral action for health: the role of intersectoral cooperation in national strategies for health for all. Geneva, World Health Organization, 1986.

Cahill, K.M., Ed. *Preventive diplomacy: stopping wars before they start*. New York, Basic Books, 1987.

Cahill K.M. *A bridge to peace*. New York, Haymarket Doyma, 1988.

Report of the International Forum on Health: A Conditionality for Economic Development – Breaking the Cycle of Poverty and Inequity, Accra, Ghana, December 1991 (document WHO/DGO/92.1).

Health dimensions of economic reform. Geneva, WHO, 1992.

Health in development: prospects for the 21st century (Report of the First Meeting of the Task Force on Health in Development, Geneva, June 1994). Geneva, WHO, 1994 (document WHO/DGH/94.5).

Cranna, M., ed. *The true cost of conflict*. London, Earthscan Publications, 1994.

Ninth General Programme of Work covering the period 1996-2001. Geneva, WHO, 1994.

Report of the Second Meeting of the Task Force on Health in Development (Amman, Jordan, December 1994). Geneva, WHO, 1995 (document WHO/DGH/95.4).

Declaration on the Centrality of Health in Social Development. Adopted by the Task Force on Health in Development at the meeting "Health, Development and Poverty" (Paris, 17 February 1995). Geneva, WHO, 1995.

Health in social development. WHO Position Paper for the World Summit for Social Development (Copenhagen, March 1995). Geneva, WHO, 1995 (document WHO/DGH/95.1).

Report of the Third Meeting of the Task Force on Health in Development (Geneva, December 1995). Geneva, WHO, 1996 (document WHO/HPD/96.1).

Report of the Fourth Meeting of the Task Force on Health in Development (Geneva, May 1996). Geneva, WHO, 1996 (document WHO/HPD/96.6).

Report of the Consultation on Health as a Bridge for Peace (Geneva, 15 May 1996). Geneva, WHO, 1996 (document WHO/HPD/96.7/Rev.1).

"Partnerships for health in the 21st century". Working paper prepared by the Working Group on Partnerships in the Context of Health-for-All Renewal. Geneva, WHO, 1996 (document HPR/96.3, draft No. 3).

Annex 4

Universal Declaration of Human Rights

Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people.

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Na-tions, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly,

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end

that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1
All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2
Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3
Everyone has the right to life, liberty and security of person.

Article 4
No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5
No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6
Everyone has the right to recognition everywhere as a person before the law.

Article 7
All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8
Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9
No one shall be subjected to arbitrary arrest, detention or exile.

Article 10
Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11
1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12
No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13
1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14
1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.
2. No one may be compelled to belong to an association.

Article 21

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
2. Everyone has the right to equal access to public service in his country.

3. This will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary

education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible

2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing true recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Annex 5

International Covenant on Economic, Social and Cultural Rights

Adopted and opened for signature, ratification and accession by General Assembly resolution 2200 A (XXI) of 16 December 1966

ENTRY INTO FORCE: 3 January 1976, in accordance with article 27

PREAMBLE

The States Parties to the present Covenant,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights,

Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,

Agree upon the following articles:

PART I

Article 1

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.
3. The States Parties to the present Covenant, including those having responsibility for the administration of Non-Self-Governing and Trust Territories, shall promote the realization of the right of self-determination, and shall respect that right, in conformity with the provisions of the Charter of the United Nations.

PART II

Article 2

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

Article 3

The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

Article 4

The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be

compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.

Article 5

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights or freedoms recognized herein, or at their limitation to a greater extent than is provided for in the present Covenant.
2. No restriction upon or derogation from any of the fundamental human rights recognized or existing in any country in virtue of law, conventions, regulations or custom shall be admitted on the pretext that the present Covenant does not recognize such rights or that it recognizes them to a lesser extent.

PART III

Article 6

1. The States Parties to the present Covenant recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.
2. The steps to be taken by a State Party to the present Covenant to achieve the full realization of this right shall include technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.

Article 7

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

(a) Remuneration which provides all workers, as a minimum, with:

(i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;

(ii) A decent living for themselves and their families in accordance with the provisions of the present Covenant;

(b) Safe and healthy working conditions;

(c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;

(d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays.

Article 8

1. The States Parties to the present Covenant undertake to ensure:

(a) The right of everyone to form trade unions and join the trade union of his choice, subject only to the rules of the organization concerned, for the promotion and protection of his economic and social interests. No restrictions may be placed on the exercise of this right other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;

(b) The right of trade unions to establish national federations or confederations and the right of the latter to form or join international trade-union organizations;

(c) The right of trade unions to function freely subject to no limitations other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;

(d) The right to strike, provided that it is exercised in conformity with the laws of the particular country.

2. This article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces or of the police or of the administration of the State.

3. Nothing in this article shall authorize States Parties to the International Labour Organisation Convention of 1948 concerning Freedom of Association and Protection of the Right to Organize to take legislative measures which would prejudice, or apply the law in such a manner as would prejudice, the guarantees provided for in that Convention.

Article 9

The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Article 10

The States Parties to the present Covenant recognize that:

1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.
2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.
3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.

Article 11

1. The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.
2. The States Parties to the present Covenant, recognizing the fundamental right of everyone to be-free from hunger, shall take, individually and through international co-operation, the measures, including specific programmes, which are needed:

   (a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such

a way as to achieve the most efficient development and utilization of natural resources;

(b) Taking into account the problems of both food-importing and food-exporting countries to ensure an equitable distribution of world food supplies in relation to need.

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 13

1. The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace.
2. The States Parties to the present Covenant recognize that, with a view to achieving the full realization of this right:

(a) Primary education shall be compulsory and available free to all;

(b) Secondary education in its different forms, including technical and vocational secondary education, shall be made generally available and accessible to all by every appropriate means, and in particular by the progressive introduction of free education;

(c) Higher education shall be made equally accessible to all, on the basis of capacity, by every appropriate means, and in particular by the progressive introduction of free education;

(d) Fundamental education shall be encouraged or intensified as far as possible for those persons who have not received or completed the whole period of their primary education;

(e) The development of a system of schools at all levels shall be actively pursued, an adequate fellowship system shall be established, and the material conditions of teaching staff shall be continuously improved.

3. The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to choose for their children schools, other than those established by the public authorities, which conform to such minimum educational standards as may be laid down or approved by the State and to ensure the religious and moral education of their children in conformity with their own convictions.

4. No part of this article shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principles set forth in paragraph 1 of this article and to the requirement that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 14

Each State Party to the present Covenant which, at the time of becoming a Party, has not been able to secure in its metropolitan territory or other territories under its jurisdiction compulsory primary education, free of charge, undertakes, within two years, to work out and adopt a detailed plan of action for the progressive implementation, within a reasonable number of years, to be fixed in the plan, of the principle of compulsory education free of charge for all.

Article 15

1. The States Parties to the present Covenant recognize the right of everyone:

(a) To take part in cultural life;

(b) To enjoy the benefits of scientific progress and its applications;

(c) To benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the conservation, the development and the diffusion of science and culture.

3. The States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.

4. The States Parties to the present Covenant recognize the benefits to be derived from the encouragement and development of international contacts and co-operation in the scientific and cultural fields.

PART IV

Article 16

1. The States Parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognized therein.

2. (a) All reports shall be submitted to the Secretary-General of the United Nations, who shall transmit copies to the Economic and Social Council for consideration in accordance with the provisions of the present Covenant;

(b) The Secretary-General of the United Nations shall also transmit to the specialized agencies copies of the reports, or any relevant parts therefrom, from States Parties to the present Covenant which are also members of these specialized agencies in so far as these reports, or parts therefrom, relate to any matters which fall within the responsibilities of the said agencies in accordance with their constitutional instruments.

Article 17

1. The States Parties to the present Covenant shall furnish their reports in stages, in accordance with a programme to be established by the Economic and Social Council within one year of the entry into force of the present Covenant after consultation with the States Parties and the specialized agencies concerned.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Covenant.
3. Where relevant information has previously been furnished to the United Nations or to any specialized agency by any State Party to the present Covenant, it will not be necessary to reproduce that information, but a precise reference to the information so furnished will suffice.

Article 18

Pursuant to its responsibilities under the Charter of the United Nations in the field of human rights and fundamental freedoms, the Economic and Social Council may make arrangements with the specialized agencies in respect of their reporting to it on the progress made in achieving the observance of the provisions of the present Covenant falling within the scope of their activities. These reports may include particulars of decisions and recommendations on such implementation adopted by their competent organs.

Article 19

The Economic and Social Council may transmit to the Commission on Human Rights for study and general recommendations or, as appropriate, for information the reports concerning human rights submitted by States in accordance with articles 16 and 17, and those concerning human rights submitted by the specialized agencies in accordance with article 18.

Article 20

The States Parties to the present Covenant and the specialized agencies concerned may submit comments to the Economic and Social Council on any general recommendation under article 19 or reference to such general recommendation in any report of the Commission on Human Rights or any documentation referred to therein.

Article 21

The Economic and Social Council may submit from time to time to the General Assembly reports with recommendations of a general nature and a summary of the information received from the States Parties to the present Covenant and the specialized agencies on the measures taken and the progress made in achieving general observance of the rights recognized in the present Covenant.

Article 22

The Economic and Social Council may bring to the attention of other organs of the United Nations, their subsidiary organs and specialized agencies concerned with furnishing technical assistance any matters arising out of the reports referred to in this part of the present Covenant which may assist such bodies in deciding, each within its field of competence, on the advisability of international measures likely to contribute to the effective progressive implementation of the present Covenant.

Article 23

The States Parties to the present Covenant agree that international action for the achievement of the rights recognized in the present Covenant includes such methods as the conclusion of conventions, the adoption of recommendations, the furnishing of technical assistance and the holding of regional meetings and technical meetings for the purpose of consultation and study organized in conjunction with the Governments concerned.

Article 24

Nothing in the present Covenant shall be interpreted as impairing the provisions of the Charter of the United Nations and of the constitutions of the specialized agencies which define the respective responsibilities of the various organs of the United Nations and of the specialized agencies in regard to the matters dealt with in the present Covenant.

Article 25

Nothing in the present Covenant shall be interpreted as impairing the inherent right of all peoples to enjoy and utilize fully and freely their natural wealth and resources.

PART V

Article 26

1. The present Covenant is open for signature by any State Member of the United Nations or member of any of its specialized agencies, by any State Party to the Statute of the International Court of Justice, and by any other State which has been invited by the General Assembly of the United Nations to become a party to the present Covenant.

2. The present Covenant is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.
3. The present Covenant shall be open to accession by any State referred to in paragraph 1 of this article.
4. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.
5. The Secretary-General of the United Nations shall inform all States which have signed the present Covenant or acceded to it of the deposit of each instrument of ratification or accession.

Article 27

1. The present Covenant shall enter into force three months after the date of the deposit with the Secretary-General of the United Nations of the thirty-fifth instrument of ratification or instrument of accession.
2. For each State ratifying the present Covenant or acceding to it after the deposit of the thirty-fifth instrument of ratification or instrument of accession, the present Covenant shall enter into force three months after the date of the deposit of its own instrument of ratification or instrument of accession.

Article 28

The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions.

Article 29

1. Any State Party to the present Covenant may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate any proposed amendments to the States Parties to the present Covenant with a request that they notify him whether they favour a conference of State Parties for the purpose of considering and voting upon the proposals. In the event that at least one third of the States Parties favours such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States Parties present and voting at the conference shall be submitted to the General Assembly of the United Nations for approval.

2. Amendments shall come into force when they have been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of the States Parties to the present Covenant in accordance with their respective constitutional processes.
3. When amendments come into force they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of the present Covenant and any earlier amendment which they have accepted.

Article 30

Irrespective of the notifications made under article 26, paragraph 5, the Secretary-General of the United Nations shall inform all States referred to in paragraph 1 of the same article of the following particulars:

(a) Signatures, ratifications and accessions under article 26;

(b) The date of the entry into force of the present Covenant under article 27 and the date of the entry into force of any amendments under article 29.

Article 31

1. The present Covenant, of which the Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited in the archives of the United Nations.
2. The Secretary-General of the United Nations shall transmit certified copies of the present Covenant to all States referred to in article 26.